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Face Page

Building Bridges: Vermont's Mental Health Transformation Initiative

Project Abstract

Vermont's mental health transformation initiative*, Building Bridges*, is designed to take on the fundamental challenges to mental health transformation. Vermont proposes to use this unique opportunity to create a sustainable national model that integrates the following groups that have traditionally been bifurcated: mental health care and physical health care, the public system/funders and the private system/funders and consumers and providers.

Vermont will design and implement a Mental Health System Transformation Plan that will ensure Vermonters' mental health needs are addressed through robust and responsive organizational and delivery systems that are firmly grounded in the six goals of the New Freedom Commission, while tailored to Vermont's unique landscape and our vision for bridging the mental/physical health, public/private and provider/consumer divides.

Our vision is that Vermonters will experience a "cohesive, inter-connected, consumer and family-driven set of structures and services that focus on the health and well-being of the whole person." We will create a system where:

- Health promotion, prevention, and early intervention are an integral part of the system of care
- Consumers and families experience every interaction as part of an integrated whole
- Consumers and families covered by public or private payers can choose from a similar range of high quality evidence-based practices, emerging best practices and values-based practices
- The culture is one of hope based on recovery and resilience that respects, listens to, and takes direction from consumers and families
- Communities welcome all members and there is a place for everyone

Led by Governor James Douglas, Vermont has recently embarked on profound system reform efforts in health care and social services, guided by principles similar to those that drive this initiative. *Building Bridges* is intentionally designed to align with these efforts: the Transformation Working Group will have six working groups that reflect the focus areas of Vermont's new State Health Plan and the *Vermont Blueprint for Health*, Vermont's major initiative to integrate health care, partner consumers and providers, and activate communities for a healthier Vermont. At the regional level, *Building Bridges* will be coordinated with the new structures that are charged to collaborate across systems on behalf of the well-being of families and individuals, with an emphasis on prevention, early intervention, and strengths-based, consumer-driven services and supports. Consumer and family involvement is a driving force throughout Vermont's vision for mental health system transformation, from the development of this proposal through every aspect of project planning, implementation, and evaluation activities.

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Budget Form

Budget Form

Building Bridges: Vermont's Mental Health Transformation Initiative

A: STATEMENT OF NEED

Vermont's Vision for a Transformed Mental Health System

Vermont is ready to undertake the challenge that *real* mental health transformation presents. Governor Douglas and state leaders have initiated bold and far-reaching change efforts that are transforming the structures, functions, and service delivery systems that touch Vermonters with health, behavioral health, and human service needs. Leaders in the private sector are taking active roles in all of these initiatives. Our vision is driven by the belief that consumers, families and communities will be more healthy and resilient when the currently fragmented health and human services systems are transformed into a coherent whole that can support individuals holistically and activate the powerful resources of our diverse communities. Building Bridges will build on the values, principles, and processes that under gird Vermont's vital new cross-agency, collaborative system change initiatives.

Vermont proposes to create an unprecedented, sustainable national model for integration between the following groups that have historically been separate, posing seemingly insurmountable obstacles to widespread system change:

- Mental health care and physical health care
- Public systems and funders and private systems and funders
- Consumers and providers

Building Bridges is designed to resolve the key challenges to achieving parity and integration between mental and physical health care. We will create a viable and sustainable crosswalk between these two systems, and between publicly and privately-funded care, as well as linking with related support systems. We will respond to the New Freedom Commission goals with strategies that enable Vermonters to experience cohesive, inter-connected, consumer and family-driven structures and services that focus on the health and well-being of the whole person.

<u>What are the elements of our vision?</u>

The overarching principle of Vermont mental health system transformation is that we focus on the well-being and satisfaction of those who use the services. As we progress through the stages of system transformation, we will continually examine our activities through the lens of how individual consumers and families experience the process of change and the programs, organizations, and agencies with which they interact to meet their mental health needs. As stated in *From Policy to Service: A Quality Vision for Behavioral Health* (Daniels and Adams, 2004), "Using the metaphor of a compass, Berwick identifies the experience of individuals, families and communities as being the 'true north' and central to any effort at quality reform."

We will create a system where health promotion, prevention, and early intervention are an integral part of the system of care.

A disproportionate share of Vermont's mental health resources go towards treatment and care for those with the most serious and long-lasting illnesses and disorders. While we must absolutely maintain our commitment to individuals with the most severe disabilities, we must purposefully realign our system to also focus on prevention and promotion of individual and community protective factors. We concur with the National Association of State Mental Health

Program Directors statement: "Public health promotion and prevention are *best practices* for increasing positive functioning and resilience, decreasing the risk of developing mental illness, and facilitating recovery (NASMHPD, 2004)."

We will create a system where consumers and families will experience every interaction as part of an integrated, coordinated whole.

Too often individuals must be screened, reviewed and "qualified" for each provider. A lack of integrated information systems further hinders integrated care. Vermont's transformed system will provide entry to services through many doors, including the medical care system, will ensure one coordinated plan of care, and will achieve the following Vermont State Health Plan goal: "A comprehensive Vermont information infrastructure is in place to support implementation of all components of the model for lifelong prevention and care (VDH, 2005)."

We will create a system where consumers and families covered by public or private payers can choose from a similar range of high quality evidence-based practices, emerging best practices, and values-based practices.

Mental health is bifurcated by public versus private funding. Too often, consumers have little real choice; decisions are driven by the payer, rather than by what is most effective or preferred by individuals and families. In addition, private insurance plans do not offer consistent benefit packages, even for the same conditions. Mental health system transformation will aim to overcome these structural barriers such that consumers and families can choose the treatment supports that best meet their needs.

We will create a culture of hope based on recovery and resilience that respects, listens to, and takes direction from consumers and families.

Our system must offer multiple strategies for recovery and resiliency-based care and supports based on what consumers and families say *they* want. We pride ourselves on Vermont's strong consumer movement, but we can create more opportunities and partnerships where consumers and families take the lead and that encourage a climate of health and well-being. Educating the workforce is key to this goal. In our transformed system, consumers and families will be true leaders in their recovery, with the focus on promoting wellness rather than treating sickness.

We will create a future that welcomes all members of our communities and has a place for everyone.

Community is highly valued in Vermont; many of us live in small towns and villages where we know our neighbors, long-time traditions matter and there is a true sense of belonging. This value resonates in our approach to mental health transformation. We will work to broaden peoples' awareness and understanding, directly attacking the stigma and discrimination that still shadow mental health consumers and their families. On behalf of Vermont's small minority population, we must build cultural competency into agencies, organizations, and communities unused to dealing with diversity. We must look beyond formal systems of care, especially in our rural state where mental health services can be few and far between. Our vision is that churches and synagogues, senior centers and schools, neighborhoods and community gathering places will welcome and support community members with mental health needs.

Vermont System Transformation Needs Using the New Freedom Commission Framework

1. Americans Understand that Mental Health is Essential to Overall Health

Among the priorities identified by multiple stakeholders providing input into Vermont's recent human services reorganization was the need to align mental health with overall health. Based on this stakeholder feedback, in June of 2004 Vermont's State Mental Health Authority joined the Vermont Department of Health and now sits side-by-side with the Divisions of Public Health and Alcohol and Drug Abuse Programs. While this positions us well for transformation, there remain gaps, barriers, needs and challenges to helping Vermonters understand that mental health is essential to overall health. These include the following:

- Mental health coverage still lags behind health coverage in the private sector. This despite passage of the nation's most comprehensive Mental Health Parity Bill in 1997, requiring all public or private third-party payers operating in Vermont to provide behavioral health care coverage on par with their physical health care benefits with no arbitrary limits or exclusions,
- Poor coordination and communication between physical health and mental health providers is the rule. While most people with mental health issues first seek treatment through their primary care physicians (New Freedom Commission Subcommittee on Mental Health Interface with General Medicine, 2003), primary health care generally does not address mental illness, or substance abuse, in a comprehensive manner.
- Due to stigma and discrimination, individuals and families are less likely to seek help for mental health issues than health issues[1]
- Suicide prevention: Suicide is Vermont's 8th leading cause of death (Suicide Prevention Resource Center, 2004) On average, five times as many Vermonters commit suicide each year as are homicide victims; the highest rates are among ages 20-24 and males 65 and over.

What Needs to be Done?

- Expand Vermont's commitment to full implementation of mental health parity.
- Undertake a coordinated anti-stigma effort that addresses discrimination and misunderstanding on the part of the general public and providers, as well as individual and family reluctance to admit to and seek treatment and support for mental health needs.
- Improve the connection, communication and collaboration between physical and mental health funders and providers (e.g., co-locate mental health workers in primary care offices and provide primary care with regular psychiatric consult).
- Increase Vermont's focus on primary prevention using asset development and resilience approaches for children and families.
- Adopt and promote a statewide suicide prevention plan. Until now, Vermont has lacked a statewide Suicide Prevention Plan. However, a draft plan, based on the *National Strategy for Suicide Prevention* (US DHHS, 2001) is now under review (VDH, 2005).

2. Mental Health Care is Consumer and Family Driven

[1] The expected prevalence rate of diagnosable mental illness is 20%, yet Vermont's largest Managed Care Organizations report a yearly utilization of mental health services of 5.71% to 8.37% (VT Department of Health, Vermont State Health Plan, 2005) indicating not all individuals with a diagnosable mental illness seek treatment.

Vermont is a national leader in recognizing consumers and families as key partners in public mental health care. Consumer and family voices are well represented – by statute – at every level of decision-making. *Building Bridges* provides an ideal opportunity to share what we have learned beyond the public mental health system. Gaps, barriers, and challenges include:

- Lack of understanding of the concepts of consumer and family-driven care and a recovery and resilience orientation in the health and non-public mental health sectors.
- Duplication of services, lack of communication, high staff turnover, and poor integration of care across multiple programs and multiple systems, such that consumer and family preferences and wishes are often lost.
- Insufficient number, diversity, and impact of consumers and families on advisory groups, task forces and boards, including those of non-mental health organizations that deal with mental health issues (e.g., elder services, corrections, homeless programs).
- Stigma and discrimination that discourages consumers and families from self-identifying and speaking out.

<u>What Needs to be Done?</u>

- Undertake a largely consumer and family-run training/TA effort on consumer and family-driven care based on respect, recovery, and resilience for all Department of Health divisions and Agency of Human Services departments, and for private mental health, health, and substance abuse providers.
- Initiate recovery and resilience models across systems of care.
- Develop a coordinated approach to ensure a single individualized plan of care for every child and adult receiving mental health services from one or more other systems that integrates services and supports across systems.
- Work with consumer and family organizations and with public and private provider organizations to recruit, train, and welcome full involvement of a diverse range of consumers on advisory groups, task forces and boards of organizations that serve people with mental health needs.

3. Disparities in Mental Health Services Are Eliminated

Vermont is a sparsely-populated rural state with only one moderately urban area, which means that access to appropriate and timely mental health care is a continuing challenge. With a population that is over 96% white, there are few resources specifically geared to those from different racial or cultural backgrounds, or who speak little English. Vermont's refugee resettlement program is bringing more minorities to Vermont, along with cultural, language and mental health issues such as trauma histories. The divide between the public and private mental health systems is also a key disparity. Gaps, barriers and challenges in this area include:

- Both private and public providers struggle with attracting and retaining a qualified workforce[2,3], especially in rural Vermont. Hospitals and CMHCs alike identify a lack of psychiatrists as a major gap in services[3]; a number of counties have no child psychiatrists.

[2] In 2005, between 60% (Children's MH Services) and 35% (Adult MH Services) of staff at CMHCs had been working at their agency for less than two years (Pandiani & Boyd, March 25, 2005; Pandiani & Boyd M, March 18, 2005; Pandiani & Boyd February 25, 2005)

- The distance to services and lack of transportation, combined with harsh weather, contribute to isolation of consumers and families. This is especially true for elders[4], individuals with physical disabilities and for many with limited incomes.
- Most mental health providers lack a diversity of mental health staff from different ethnic backgrounds, and there is a general unavailability of culturally competent services.
- Remote areas often lack even high priority services, such as crisis outreach and regional hospital diversion beds[3], and there is a great disparity of access to services among community mental health centers[5] (Pandiani, Banks, Bramley, et al, 2002).
- While Vermont's publicly funded services have developed a continuum of services, especially for individuals with the most severe disabilities, the private sector has limited options for those needing multiple services over a lengthy period of time; it lacks the comprehensiveness, coordination and oversight available in the public system.
- The majority of primary care physicians who prescribe and monitor psychotropic medications do so without any involvement of psychiatrists.

What Needs to be Done?

- Develop a workforce recruitment, retention and development plan to find and keep qualified mental health professionals, especially in rural areas, and provide them with the competencies and understanding to effectively serve all Vermonters, respecting their choices and lifestyles.
- Provide cultural competence and diversity training and translators through a central resource that ensures ready statewide availability, even in remote areas.
- Enhance peer and family helping networks in rural areas.
- Use *Building Bridges* to identify the disparities in the benefit package between publicly and privately funded care and work towards similar service availability and quality.

4. Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Screening, assessment, and referral are areas where the divide between public and private providers and between mental health, physical health, and substance abuse treatment pose significant barriers to excellence. Our proposed organizational framework and our strategies to bring together these traditionally separate entities will enable Vermont to embark on groundbreaking efforts that will result in far earlier, more effective, and consumer and family centered screening, assessment and referral practices. Gaps, barriers, and challenges include:

- The general lack of early identification of mental health problems for all age groups, despite prevalence (e.g. seven percent of older Vermonters are designated as at-risk for depression[6])
- Primary care physicians do not have good tools and information for screening nor are there adequate procedures to insure timely referrals or to coordinate care.

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[3] As identified by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) Health Resource Allocation Plan, a comprehensive assessment of human resource needs across all health care professionals.

[4] As identified by the Vermont Health Plan (see Section B)

[5] As measured by comparing utilization rates of mental health services in different areas of state in relation to expected prevalence of mental health needs.

[6] Based on CDC's Behavioral Risk Factor Surveillance System, www.cdc.gov/brfss.

- Insufficient understanding among health, mental health professionals and the public at large of the importance of identifying and responding to the mental health needs of young children (age 0-6) and their families.
- The public system allocates insufficient resources to early intervention and effective services to individuals whose illness is less severe.

What Needs to Be Done?

- Adopt statewide policies and funding to significantly increase screening and assessment for mental health issues before they become serious mental health problems. This must include specific strategies for early childhood and elderly persons; for school-based screening and screening; and in other systems of care such as corrections, juvenile justice child welfare.
- Create effective cross-referral systems between CMHCs and private mental health providers and between mental health and primary care providers to ensure that all Vermonters receive needed care, not just those most seriously ill.
- Develop and train mental health, substance abuse, and primary care providers in integrated screening, assessment, and referral strategies for co-occurring mental health and substance abuse disorders through Vermont's recent SIG grant for co-occurring disorders and build this into Vermont's Mental Health Transformation Plan.
- Expand on gains made through Vermont's recent CMHS grant focused on increasing knowledge about and resources to meet the mental health needs of children from birth to six and their families – increase the circle of collaborators to private sector mental health and to health care professionals and reach out to parents as partners.
- Use public education to increase public understanding and acceptance of mental health screening.
- Identify and address obstacles to screening, assessment, and referral that may be unique to certain groups (e.g., S.E. Asian refugees, incarcerated individuals, persons who are homeless) areas of the state (e.g., dearth of services and specialists for referrals in the isolated Northeast Kingdom), or set of providers (e.g., daycare providers unable to attend daytime training).

5. Excellent Mental Health Care is Delivered and Research is Accelerated

Vermont widely implements practices shown to be effective, with five of the six nationally-identified evidence-based mental health practices for adults in use in Vermont CMHCs. We have also been a leader in providing practice-based evidence, especially in children's services. In addition, Vermont is an innovator in defining and implementing promising emerging practices and values-based practices. We must broaden the base of understanding and adoption of these practices by private providers; make available training, continuous quality improvement, and assessment; and create financial incentives to ensure excellent practice and outcomes for professional and consumer and family-run services. Gaps, barriers, and challenges include:

- A lack of agreement among public and private providers on what "excellent mental health care" is and how it should be measured and evaluated.
- Management of mental health systems that tends to reflect financial pressures more than quality and need (e.g. funding for public services changes yearly based on state revenue) with funding instability limiting the ability to develop and maintain excellent practices.
- Lack of technology to measure quality and effectiveness of services for people involved in multiple systems of care, especially across health, mental health, and substance abuse.

- High staff turnover[2] at community mental health centers (CMHCs) means that knowledge and skills on excellent mental health care are continually lost.
- Vermont's only state hospital is currently decertified and functions as an isolated institution from the rest of our health care and mental health delivery systems.

What Needs to be Done?

- Develop consensus on the definition of "excellent mental health care."
- Use the proposed collaboration between the *Vermont Blueprint for Health* and *Building Bridge*s to develop public/private and mental/physical health service demonstration and evaluation efforts, making use of the Probabilistic Population Estimation data analysis strategy already in use by DMH.
- Collaborate with the Agency of Human Services Trauma Initiative to ensure access to appropriate and timely mental health interventions integrated with other supports, based on the most promising national models.
- Design and carry out a system of services and supports for youth transitioning to adulthood, drawing from current evidence-based and best practices, addressing funding barriers.
- Expand upon the current DMH CQI processes to provide feedback on gaps, service and system improvement needs, and successes for all providers of mental health services, including physical health care providers; specifically consider broader use of the Institute for Healthcare Improvement "Breakthrough Series" model of collaborative improvement and the Plan, Do, Study, Act (PDSA) model of action-oriented learning (IHI, 2005).
- Continue to develop and implement an early childhood system of care, in conjunction with the governor's Building Bright Futures initiative.
- Lengthen the state budget cycle for mental health care from the current annual allocation to 3-5 year cycles to allow for sufficient time for the system to undertake transformation.
- Link inflationary cost increases in mental health to general health care cost trends, allocate resources and enhance rates accordingly.
- Transform Vermont's stand-alone state hospital into a state-of-the-art facility operated by and integrated with a major medical center.

6. Technology is Used to Access Mental Health Care and Information

Vermont has made great strides in electronic data collection and tracking across the CMHCs and public mental health system. However, limited capacity to collect data from private providers or health care providers means little is known about service availability, gaps and strengths, or even the numbers of people served and services provided. Creating the capacity to collect and report data from all providers is key to system improvement. Equally important is creating a cross-system electronic MIS or patient registry that enables clinical data sharing among providers, while guaranteeing confidentiality, to improve service integration, efficiency, and outcomes. As a rural state with a shortage of specialists, Vermonters should better use technologies that enable sharing expertise from afar. Gaps, barriers, and challenges include:

- Private and public databases are not integrated concerning mental health.
- Lack of leadership to develop telemedicine and other technology-assisted supports and services.
- Inefficient collection and use of currently available health data
- Little use of electronic record-keeping among physicians and private mental health practitioners.

- Lack of access to computers on the part of low-income consumers and families and unavailability of high-speed Internet access for rural providers, consumers and families.
- Cultural barriers to elderly persons accessing technology.
- Unavailability of education and training in multiple media formats.
- Lack of compatibility in computer software and networks to share health information.

What Needs to be Done?

- Design flexible web-based systems for clinical data to integrate and improve care across systems, including primary care, while maintaining confidentiality and consumer protections.
- Provide education and training materials in multiple media formats, tailored for providers and consumers and families.
- Develop and use telemedicine to aid primary health care providers in addressing mental health issues and to provide specialized expertise in remote areas.
- Expand electronic recordkeeping and data reporting to better enable evaluation of system and service improvements, client outcomes, costs, and emerging needs and strengths.
- Develop a data warehouse capacity for all mental health-related care; design access to this information for all health and mental health provider groups.

Description of Stakeholders and Inventory of Resources

Building Bridges will build a statewide "community," that creates new connections and strengthens existing ones between private and public, consumers and providers and physical health and mental health. To that end, the following groups and agencies, each of which has an important role in mental health system transformation, will be represented on the Transformation Working Group (TWG):

Consumers and Families: *Vermont Psychiatric Survivors,* a statewide consumer organization, *the National Alliance for the Mentally Ill of Vermont (NAMI-VT) and* the *Vermont Federation of Families for Children's Mental Health* all providing advocacy, education, training, and support. The *Community of Vermont Elders,* a statewide consumer advocacy organization for Vermont's seniors. Finally, the TWG will include consumer and family members from *Vermont's Mental Health Planning Council.*

Mental Health Providers: The *Vermont Council of Developmental and Mental Health Services,* the statewide advocacy organization representing Vermont's 10 nonprofit, publicly-funded Community Mental Health Centers (CMHCs). In 2004 these agencies served approximately 10,500 children and youth and over 10,300 adults. *The Council of Mental Health and Substance Abuse Professionals of Vermont*, an advocacy organization that represents psychiatry, social work, psychology, mental health counseling, substance abuse counseling, and psychiatric nursing in both the public and private sectors. The *Veterans Administration Association of Hospitals and Health Care Services.* The *Vermont Refugee Resettlement Program*, which provides services and supports to foreign refugees being resettled in Vermont, most who are fleeing intolerable conditions in Southeast Asia, Eastern Europe and Sub-Saharan Africa. The *Vermont Association of Hospitals and Health Care Systems,* representing Vermont's community hospitals and the five facilities which provide inpatient psychiatric treatment.

Public Health Stakeholders *The Northeastern Vermont Area Health Education Center (AHEC),* one of Vermont's three Area Health Education Centers that partner with the University of Vermont College of Medicine and the *Burlington Community Health Center,* one of Vermont's

four Federally Qualified Health Centers providing health care to people who are uninsured or underinsured.

Private Insurance Stakeholders Two major private insurance companies, *MVP* and *Blue Cross Blue Shield* **(**and its behavioral health partner*, Magellan Health Services*).

State Government*:* The following top managers for the *Agency of Human Services (AHS)*will serve on the TWG: the Coordinator of Field Services and the Director of Housing and Transportation., the *Office of Vermont Health Access,* which administers Vermont's Medicaid Program, and the AHS Trauma director,. Representation from *the Department of Health (VDH),* which provides essential health promotion, protection and disease prevention services and serves as the state's lead agency for public health policy and advocacy will include high-level staff responsible for health promotion and prevention, In addition, *Alcohol and Drug Abuse Programs*, which oversees substance abuse prevention and treatment services and the *Division of Mental Health (DMH),* the state mental health authority will serve on the TWG. Other AHS departments represented on the TWG are: *Department of Children and Families,* which focuses both on child protective services and a wide range of economic and social support services and the *Department of Aging and Independent Living (DAIL)*, which assists older Vermonters and people with disabilities to live as independently as possible. The Department also protects vulnerable adults from abuse, neglect, and exploitation and provides public guardianship to elders and people with developmental disabilities. In addition, *DAIL's Division of Vocational Rehabilitation,* which works to support individuals with disabilities in finding and keeping meaningful employment and *the Department of Corrections* will serve on the TWG.

Other Department of state government providing resources and representation to the TWG are *the Health Care Administration* of the *Vermont Department of Banking, Insurance, Securities and Health Care Administration*, which regulates commercial health insurers (including managed care organizations) and the *Department of Employment and Training,* provides services, information, and support to individuals to obtain and keep good jobs, and to employers to recruit and maintain a productive workforce. Finally, the *Department of Education, Division of Special Education*, which works closely with the Division of Mental Health and the Department of Children and Families to ensure that children with disabilities and special needs receive the proper supports and services to achieve a full education will be part of the TWG.

The following are identified resources that these stakeholders bring to Building Bridges that can contribute to mental health transformation:

Type of Resource that Can Support MH Transformation	***Description of Resource and Source/Stakeholder***
Facilities & Equipment for Grant Staff	1) Newly renovated office space in Burlington for Building Bridges staff (DMH) 2) Computer stations for all staff with access to Microsoft Office, Email, Internet (DMH
Information Systems, Access to MH-Related Data, and Ability to Report Data and Outcomes	1) Existing Managed Care Information System (MCIS): data warehouse with comprehensive CMHC and VSH client and service data; updated monthly (DMH) 2) Performance Indicator Project (DMH): sophisticated outcomes reporting developed with stakeholder community using existing data bases across state government; include access to all Medicaid paid services (Office of Vermont Health Access), employment data reported to state (Dept. of Employment and Training), and incarceration rates (Dept. of Corrections), 3) Statewide development of Homeless Management Information System (HMIS) to track services provided to homeless mentally ill (Agency of Human Services)

Ongoing Funding for MH Services	1) Division of Mental Health yearly budget of $126,800,000. Includes: a) State General Funds-$39.8 Million, b) Federal Medicaid Funds-$56.2 Million, c) Federal MH Block Grant-$803,122. d) Other Federal Grants: $1.2 Million, e) Dept. of Education funding for services-$8.8 million, f) Other AHS Dept. Funding for services-$10 million
Specialized Services for populations with unique MH needs that can be expanded upon for further MH Transformation	1) Eldercare Clinician Program to provide outreach and mental health treatment to elders (Dept. of Aging and Independent Living) 2) Mobile Methadone Treatment for rural areas (Div. Of Alcohol and Drug Abuse) 3) Statewide JOBS program to provide intensive mental health case management along with employment services and supports for transition age youth who have dropped out of school and/or had involvement with juvenile justice or adult corrections (Div. Of Vocational Rehabilitation & DMH) 4) Community based collaborative programs for children 0-6 (and their families) with a goal of early identification and intervention with social-emotional-behavioral challenges (DMH), 5) Co-Occurring Disorders Treatment Pilot Programs for individuals with serious mental illness and substance disorder in trouble with the law (DMH, Div. Of Alcohol and Drug Abuse Programs, Dept. Of Corrections)
Grant-Funded Projects for Improving MH and Related Services	1) 5-year SAMHSA State Prevention Framework State Incentive Grant ($2.38 million/year) to build prevention capacity and infrastructure at state and community levels 2) Expanding Adolescent Treatment Services grant from the Center for Substance Abuse Treatment to fund pilot sites in Vermont, with funding of approximately $250,000 / year for three years in the Division Of Alcohol and Drug Abuse Programs 3) Federal Maternal Child Health Bureau Early Childhood Comprehensive Systems Grant (submitted—under review) for $405,000/year for 4 years, to improve early childhood mental health and social-emotional development (Dept. for Children and Families) 4) National Governor's Association Center for Best Practice Grant of $48,000/year for two years to develop systems for early screening and detection of depression in elders (Dept. of Aging and Independent Living) 5) CMH Real Choices Systems Change Grant to design better system for management of health care for elders and people with physical disabilities (Div. Of Aging and Independent Living) 6) Social Security Administration Grant for pilot studies to reduce barriers for individuals with disabilities to return to work (Div. Of Vocational Rehabilitation) 7) 3-year SAMHSA State Consumer Network Grant ($70,000/year) to develop expand consumer leadership, peer-run programs, and recovery education (Vermont Psychiatric Survivors) 8) "Moving Ahead" Project funded through CMH Real Choices Grant ($120,000) to use recovery education to reduce use of involuntary treatment (DMH & Vermont Psychiatric Survivors) 9) 3-Year SAMHSA State Family Network Grant ($70,000/year) to develop and foster leadership and build community-based support (VT Federation of Families) 10) Robert Wood Johnson Foundation funding to improve integration of primary and behavioral health services (Office of VT Heath Access) 11) SAMHSA State Incentive Grant for Co-Occurring Disorders (COSIG) ($4.5 million over 5 years) to enhance state infrastructure to support integrated mental health & Substance Abuse Treatment (DMH) 5) 3-Year SAMHSA Evidence-Based Practice Training and Evaluation Grant ($325,000/year) to implement Integrated Dual Disorder Treatment (DMH)
Ongoing Projects or Initiatives for Improving MH and Related Services	1) Advisory Council on Elder Mental Health, Dementia, and Substance Abuse (Dept. of Aging and Independent Living, DMH) 2) DMH State Supported Employment Coordinator (funded by Div. Of Vocation Rehab & DMH) to support CMHC use of supported employment for individuals with mental illness and youth with SED 3) Regional Benefits Counselors (funded by Div. Of Vocational Rehab) to assist

	individuals with disabilities with increasing work income without losing medicaid/medicare/health insurance 4) BEST Initiative to provide MH training to educators and community-based partners (Dept. of Education, DMH) 5) Statewide Recovery Education project (Vermont Psychiatric Survivors) 6) Statewide education for families (Family to Family Journey of Hope) and provider education re: supporting families (NAMI-VT) 7) Blueprint for Health: statewide initiative with involvement of insurers, physicians, hospitals, University of Vermont, and state departments to improve care for individuals through innovative chronic care initiatives (VT Dept. of Health) 8) "Building Bright Futures: Vermont's Alliance for Children:" innovative partnership under the leadership of the Governor's office, comprised of private sector providers, families, business leaders, community members and state government decision makers designed to create a unified, sustainable system of early care, health, and education for young children and their families to ensure that all Vermont Children will be healthy and successful. 9) Clinical Practices Advisory Panel: statewide stakeholder group established to review and develop implementation recommendations for state re: evidence-based, promising, and values-based practices (VT Council of Developmental and MH Services, DMH) 10) Trauma Cluster for developing trauma informed human services (AHS) 11) Vermonters for Suicide Prevention and Draft State Suicide Plan
Laws, Acts, Regulations and Policies to Support Quality Mental Health Services	1) Vermont Act 264: Gives youth with serious emotional disturbance entitlement to coordinated service plan and established statewide network of 12 Local Interagency Teams and 1 State Interagency Team to ensure Act is complied with; involves DMH, Dept. of Education, and Dept. for Children and Families. 2) Vermont MH Parity Law (see section A) 3) Vermont Act 113: requires board of directors of CMHCs to have 51% consumer and family membership 4) DMH Designated Agency Regulations: requires CMHCs and DMH to have advisory boards for mental health services with 51% consumer and family membership 5) Current negotiation with CMS to "block grant" entire Medicaid program - Global Commitment - to expanded flexibility in using Medicaid across health and human services (AHS, Office of Vermont Health Access)
Networks of stakeholders that can be accessed for input and involvement in MH transformation	1) Over 70 consumers, family members and professionals trained as Recovery Educators by Mary Ellen Copeland through Vermont Recovery Education Project (Vermont Psychiatric Survivors 2) Statewide networks of a) psychiatric survivors/mental health consumers/ex-patients (Vermont Psychiatric Survivors), b) family members (NAMI-VT, VT Federation Families, c) mental health and substance abuse professionals (Council of MH and SA Professionals, VT Council of Developmental and MH Services), d) psychiatrists (Vermont Psychiatric Association, e) physicians (Vermont Medical Society), f) health care clinics (Vermont Coalition of Clinics for the Uninsured), and g) hospitals (VT Assoc. of Hospitals and Health Care Administrators. 3) statewide community groups of consumers and families and of public and private providers (AHS regional Partnerships, District Leadership Teams, and District Advisory Councils)
Vermont Based Expertise and Experience that will support MH transformation	1) Veteran's Administration National Center for the Study of Post Traumatic Stress Disorder 2) Significant experience using Medicaid waivers including Home and community based waivers and 1115B Research and Demonstration waiver to expand access to health insurance for Vermont's working poor (Office of Vermont Health Access) 3) Area Health Education Center's experience collaborating with and training health care system
Key People who can influence MH transformation	1) Chair of Vermont State Senate and House Health and Welfare Committees will serve on TWG.

Population Demographics

Vermont is a small state with a population of 608,827 (U.S. Census Bureau, 2004) and is one of the most rural states in the country: Burlington, the state's largest city, has a population of only 39,000, and most Vermonters live in or near communities with populations of 2,000 to 20,000. Some regions, especially the three counties comprising Vermont's "Northeast Kingdom," are particularly isolated and quite impoverished, with many residents having little access to mental health or other human services.

The state's population is overwhelmingly white: 96.8%, according to 2000 census data. No minority group comprises even 1% of Vermont's population. The majority of the small number of African Americans (.9%) lives in the Burlington area. Burlington is also home to a community of Asian, African, and Eastern European immigrants relocated by Vermont's Refugee Resettlement Program. Most Native Americans live in Northwestern Vermont, including Vermont's largest tribe, the Abenaki Nation, with about 1500 members.

Prevalence of Mental Illness: Adults:

SAMHSA county level estimates of the prevalence of serious mental illness indicate that 24,556 adult residents of the state fall into this category (SAMHSA, 2002). In 2004, the public mental health system served 3,205 adults with severe and persistent mental illness and another 7,200 with serious mental illness indicating that only half of the expected need is being met by the public mental health system (VDDMHS, 2004).

Vermont's suicide rate is 12.6 per 100,000. Suicide is the 8th ranking cause for death overall, and the 7th ranking cause for death among Vermont males. Males over 65 are at particularly high risk for suicide, at 22 per 100,000 individuals (VDH, 2004).

Prevalence of Children and Youth with Emotional Disturbances:

The number of Vermont children and youth estimated to be in need of mental health treatment annually is approximately 28,000. This is based on the U.S. Surgeon General Report's estimate that approximately 20% of children and adolescents experience the signs and symptoms of a mental health disorder that has a negative effect on well-being and/or ability to function in daily life in any given year (U.S. DHHS, 1999). According to the federal Center for Mental Health Services, close to 17,000 (about 12%) of Vermont children and youth may experience a severe emotional disturbance in the course of a year (SAMHSA, 2002).

In 2003, the Vermont Division of Mental Health served approximately 10,600 children and adolescents and their families with community mental health services (DDMHS, 2004). This included those who were experiencing a severe emotional disturbance as well as those at substantial risk for developing an emotional disturbance. As with adult mental health services, a significant shortfall remains between need and capacity in Vermont's mental health system.

During FY2002, Vermont's child protection agency served almost 1,400 young people who had been the victims of abuse and/or neglect. Only 30% of those trauma victims were served by Vermont's public community mental health system during the same year. Again, there is a substantial unmet need for services (DDMHS, 2004).

Related Risk and Protective Factors

The Vermont Division of Mental Health has devoted considerable attention to importance of risk factors in determining a child's need for mental health services. The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health (DDMHS, 2004) states:

"Risk factors from the child's environment may include: Physical, sexual or emotional abuse; physical trauma; domestic violence and substance abuse in the family system; severe neglect; malnutrition, ill health, lack of caring adults, numerous transitions; unsafe or unsanitary living conditions; exposure to familial violence; harsh or inconsistent discipline; having one or two parents with a psychiatric disability…many of these are related to living in poverty.

Risk factors from the child's biological make-up may include: Genetic, neurological and biochemical factors such as family history of depression, learning difficulties (especially reading), impulsivity and temperament. In some situation medical conditions such as allergies, asthma, traumatic brain injury, seizure disorder, etc. can be the direct cause of emotional and behavioral difficulties…And…exposure to toxins (environmental, chemical and nutritional)."

To prevent and lessen the impacts of these risk factors, and increase protective factors, DMH recommends several strategies, including "…prenatal and perinatal medical care, childhood immunizations, home visiting and other forms of parenting support and training, high quality early care and education and success in school. Public children's mental health services can offer parenting support and training and can help children learn self-control and social skills."

High among the risk factors we must address for Vermont adults is trauma, including domestic violence, violent crime, sexual assault, PTSD (post-traumatic stress disorder), the dislocation experienced by Vermont's refugee population, and elder abuse. Another priority is the many Vermonters living in rural areas, especially elderly persons, who are at risk for depression due to isolation and lack of social supports, particularly during Vermont's long and harsh winters.

The Vermont State Health Plan, the *Blueprint for Health*, and the new AHS Strategic Plan all focus on identifying risks and improving protective factors for Vermonters through targeted prevention and intervention strategies.

B. APPROACH: ORGANIZATIONAL STRUCTURE

Governor's Commitment to Mental Health Transformation and Willingness to Take Risks for Meaningful Transformation

Governor Douglas views the *Mental Health Transformation State Incentive Grant* as an exciting and timely opportunity that dovetails with the major reform initiatives he has championed to improve the health and welfare of Vermonters throughout his tenure as Vermont's governor.

The new Vermont Health Plan, the *Blueprint for Health,* the AHS Reorganization, and the Global Commitment to Healthcare proposal to restructure Medicaid are bold system reform efforts that demonstrate the governor understands that real transformation requires dramatic change. Through them, Governor Douglas, and his leadership team of agency heads, have shown the will to take real risks, to "shake things up" in profound and far-reaching ways to create comprehensive, effective and sustainable systems of care that actively partner providers and consumers, activate communities, and focus on increasing Vermonters' health and well-being.

The *Vermont Health Plan*, for example, describes an ambitious vision "that the State will be a model for the rest of the nation, with the healthiest people, living in healthy communities, with a proactive health system and a public health and government infrastructure that work collaboratively to minimize risks, prevent disease and disability, promote health, ensure access and provide state-of-the-art care (Vermont Health Plan, 2005)."

The governor recently spoke about the *Vermont Blueprint for Health*, calling the $235 million, 5-year plan a package of "sweeping reforms" that will "give Vermonters the tools and incentives they need to stay healthy and make healthy decisions, dramatically improve the quality of care we offer and help us to prevent costly and debilitating disease (Douglas, 2005)."

The *AHS Reorganization* effort was accomplished through unprecedented public input, with multiple strategies used to solicit information from consumers, employees, contracted providers, advocates, and other partners. The AHS Reorganization Plan represents a substantial organizational realignment, with new structures, roles, and partnerships aimed at carrying out the new AHS Mission: "AHS works as one agency, in partnership with communities, to provide effective services that are delivered respectfully, easy to access, well coordinated, and aimed at promoting well-being and intervening before crisis."

The governor's *Global Commitment to Healthcare* proposed Medicaid waiver demonstration is "built on the premise that health coverage needs to be comprehensive and continuous. Coverage for essential health services needs to be in place for all Vermonters throughout their lives…It…puts in place a series of health coverage options to achieve the goal of universal access to health care in Vermont (Office of Vermont Health Access, 2005)."

Governor Douglas has also demonstrated his commitment to strengthening Vermont's mental health system, both through the recent relocation of the Division of Mental Health to the Department of Health to ensure parity and a public health perspective, and through his proposed budget, which calls for a 7.5% annual increase for designated agency providers (CMHCs) for the next several years.

Transformation Working Group Chair

Governor Douglas has selected Charles (Charlie) Biss, currently Director, Vermont Division of Mental Health Child, Adolescent and Family Unit, as our dynamic leader to chair the Transformation Working Group.

Transformation Working Group – Member Organizations and Mental Health Project Collaboration/Implementation Experience and Capability

Vermont has a long history of collaboration among "communities" within the mental health landscape, and the membership of the Transformation Working Group reflects this. Due to space constraints and the number of organizations on the TWG, this section highlights most key organizations and their experience with collaboration. The full list of stakeholder organizations participating on the TWG appears in Section A.

Consumers and Family Members: *Vermont Psychiatric Survivors (VPS), NAMI-VT, and the Vermont Federation of Families (VFF)* are all peer-based mental health programs that have been providing peer support, education and advocacy for over ten years. The Division of Mental Health (DMH) and these organizations regularly collaborate on projects, including: a) a statewide Recovery Education Project in which consumers and professionals teach Mary Ellen Copeland's Wellness Recovery Action Plan side-by-side to consumers (VPS), b) a pilot project, "Moving Ahead" using recovery education to help reduce involuntary treatment (VPS), c) co-hosting yearly training conferences and series for providers on involving and supporting families (NAMI-VT), d) developing and implementing respite training statewide (VFF) and e) providing training and supervision to "Peer Navigators" for parents with disabilities (VFF). The *Community of Vermont Elders (COVE)*, a consumer and advocacy organization for older Vermonters, has collaborated with DMH on a number of projects, including a recent

Administration on Aging Mental Health Grant, for which COVE developed curricula and provided education on such topics as *Mental Health in Later Years, Rx Mix and Match*, and *The Blues-Not Just a Normal Part of Aging.*

Mental Health Providers: Because the *Vermont Council of Developmental and Mental Health Services (VCDMHS)* represents the 10 designated community mental health agencies (CMHCs) with which DMH contracts, DMH and VCDMHS commonly work together, including on the following current initiatives: a) Vermont's new Clinical Practices Advisory Council, a statewide stakeholder group that reviews the possible implementation of evidence-based, promising, and values-based practices within the context of Vermont's mental health system and makes recommendations to the state, and b) developing an enhanced set of community based acute care services to replace many functions of the state hospital. The *Veterans Administration* is a national center for the study of Post-Traumatic Stress Disorder and will be a key player in establishing a trauma-informed mental health system. The TWG will also benefit from participation of the *Vermont Coalition of Mental Health and Substance Abuse Providers* Chair, which has been working with DMH to streamline credentialing requirements for clinicians who provide both mental health and substance abuse treatment. The Vermont Association of Hospitals and Health Care Systems is collaborating with the Division of Mental Health, helping to design a new state hospital and plan for the new and enhanced acute care management system.

Public Health Stakeholders: As a member of the Blueprint for Health, the *Northeastern Vermont Area Health Education Center* has already been assisting health providers in developing interdisciplinary teams to better integrate health and mental health, and recently established a forum series bringing together CMHCs and independent mental health providers to improve service coordination. The *Burlington Community Health Center,* whose executive director will serve on the TWG, has long collaborated with DMH and Howard Mental Health Center (the area's CMHC) to provide integrated health and mental health care under one roof and operate a federally-funded Homeless Health Care Project that annually serves over 300 individuals who are homeless and have mental illness.

Private Insurance Stakeholders: The Transformation Working Group will benefit from the membership of *Blue Cross Blue Shield/Magellan Health Services (MVP)*, which has worked for over 15 years to ensure quality behavioral health for Vermonters. Vermont has been fortunate to have a representative from *MVP* participate in the stakeholder group that helped develop this grant application, and MVP will continue to be represented on the TWG.

Minority Stakeholders: The TWG will benefit from having the *Refugee Resettlement Program*, which has worked with DMH and local community mental health agencies in Chittenden and Washington Counties to ensure appropriate, culturally sensitive mental health services are provided to area refugees, and the *Abenaki-University of Vermont-Department for Children and Family Services Partnership*, which has focused on providing culturally sensitive mental health and social services for a number of years.

State Government: Vermont state government strives to work across departments to serve those who have needs across different areas of human services, and the AHS reorganization strengthens this collaboration. The office, departments and divisions represented on the TWG have their own history of collaborating on mental health projects. The *Office of the Secretary of AHS* works closely with the Department of Health and the DMH on mental health matters requiring high level attention, including development of the annual state mental health budget. Current projects in which the Office of the Secretary is involved include the Vermont State Hospital Futures Project and the development of Vermont's application for this grant program.

The AHS Directors of Housing and Transportation, collaborators with DMH on Vermont's new Homeless Management Information System, will also serve on the TWG group. The AHS *Office of Vermont Health Access,* which oversees Medicaid, is closely tied in with DMH. Joint projects include: a) development of an innovative State 1115 Waiver amendment to fund comprehensive mental health services (e.g. wrap around, supported employment, integrated mental health and substance abuse treatment), b) grant funded projects to improve primary health care and mental health care integration, self management of physical and mental health issues, and early depression screening, c) development of connectivity between the Medicaid Paid Claims data base and DMH Information Systems.

As the Division of Mental Health joined the *Vermont Department of Health (VDH)* as part of AHS reorganization in 2004, the Commissioner of VDH, who will serve on the TWG, has taken an active role in supporting high-level mental health initiatives, including the Vermont State Hospital Futures Project and the development of this grant proposal. VDH had begun further highlighting mental health within the Blueprint for Health and the State Health Plan prior to this grant application. VDH and the Division of Mental Health are collaborating on several promising demonstration projects, two of which include the Pediatric Collaborative (places mental health clinicians in primary care practices) and the Medical Home Project (coordinates physical and mental health care of high cost consumers with disabilities). Through *Building Bridges* we can turn the successes of these pilot projects into standard practice.

The VDH *Division of Alcohol and Drug Abuse Programs* has also recently increased its collaboration with DMH, including a) two successful pilot Co-Occurring Disorders Treatment Programs for individuals with severe mental illness and a substance disorder who are in involved with the criminal justice system b) providing training and consultation resources as part of DMH's Evidenced Based Practices Training and Evaluation Grant to implement Integrated Dual Disorders Treatment, and c) acting as a co-applicant for the recently awarded SAMHSA State Incentive Grant for the Treatment Co-Occurring Disorders (COSIG) and d) giving oversight and management of child and adolescent hospitalization Medicaid funds to DMH.

The *Department of Children and Families (DCF)* has worked closely with children's mental health since the passage of Act 264 in 1988 which requires writing Coordinated Service Plans for eligible youth; developing an interagency system of care for youth with a severe emotional disturbance; and supporting a statewide system of Local Interagency Teams and a State Interagency Team to provide consultation and TA. DCF provides General Fund dollars as Medicaid match to DMH to serve youth in their care and develops Individualized Service Budgets with DMH around youth in custody with the most intensive needs. DCF has partnered with DMH on two major federal grants CMHS grants – the Child and Family Mental Health Services grant and a grant aimed at strengthening understanding, training and capacity focused on early childhood mental health.

The *Department of Aging and Independent Living* (DAIL) has long worked with DMH to improve mental health for elders. Projects with DMH include: 1) A four year old Eldercare Clinician Program based at CMHCs providing mental health outreach and treatment to elders statewide, 2) Creation of Vermont Advisory Council on Elder Mental Health, Dementia and Substance Abuse 3) National Governor's Association Center grant for early screening and detection of depression in elders, and 4) an application currently out for review for a SAMHSA Elderly Mental Health Services grant. DAIL's *Division of Vocational Rehabilitation* has also worked closely with DMH, including: 1) statewide implementation of Supported Employment with high fidelity to evidence-based practice, 2) development of regional benefits counselors to

help individuals with disabilities increase work income without losing health benefits, 3) pilot studies funded by the Social Security Administration and RWJ to reduce barriers for people with disabilities to return to work. The AHS *Department of Corrections*, which collaborates with DMH and the Division of Alcohol and Drug Abuse Programs to support the two pilot Co-Occurring Disorders Treatment Programs, will also have a representative on the TWG.

While operating outside of the Agency of Human Services, the *Health Care Administration of the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA)* has been and will be a key player in improving the mental health system. Current mental health responsibilities include: 1) implementing and enforcing Vermont's landmark Mental Health Parity Act in the private insurance market, 2) coordinating and staffing the Act 129 Mental Health and Substance Abuse Task Force to evaluate implementation of mental health parity and collecting data on health insurer coverage for mental health and substance abuse treatment. The Department of Employment and Training, which currently works with DMH research and statistics staff to use DET employment data to provide monthly reports of employment rates for individuals receiving services through community mental health.

Similarly to the Department of Children and Families, the *Department of Education* (DOE) has worked closely with children's mental health since the passage of Act 264, participating in the same kinds of coordinated service planning and participation in an interagency system of care. DOE has provided leadership to encourage Local Education Agencies (LEAs) to provide General Fund dollars as Medicaid match to DMH to provide school-based mental health services through Vermont's Success Beyond Six initiative. Success Beyond Six has expanded to include all of Vermont's supervisory unions (school districts) and has a budget of $21 million.

Role of Vermont's Mental Health Planning and Advisory Council in Mental Health Transformation

Vermont's Mental Health Planning Council will remain a separate group from the Transformation Working Group, but will play a major role in the TWG, and will both review and approve Vermont's proposed Mental Health Transformation Plan (Comprehensive Mental Health Plan) before adoption, and conduct an annual review of the Plan.

Vermont's Mental Health Planning Council includes members as specified in federal law (P.L. 102-321). At least 50 percent of the members of the Planning Council are consumers and family members, most of whom are key mental health activists and advocates. The Planning Council reviews Vermont's block grant plans and reports, and evaluates the allocation and adequacy of mental health services in Vermont. Consistent with our history, the current chair of Vermont's Planning Council is a consumer who is a respected recovery educator.

The core of Vermont's Planning Council is comprised of Vermont's two State Program Standing Committees: for Adult Mental Health and for Children and Adolescents and their Families. These policy committees meet monthly, are chaired by consumers and family members and advise the DMH in five areas of public mental health: hiring of key management; evaluation of quality; development of the State System of Care Plan; developing significant policies; and reviewing complaints, grievances, and appeals. Vermont administrative rules require that the majority of State Standing Committee members be consumers and family members; the balance is made up of providers, advocates and other stakeholders.

Vermont's Mental Health Planning Council will be integrally involved in Vermont's mental health transformation. The Chairs of each Standing Committee and six other Planning Council members, including the Chair, all consumers and family members, will serve on the

Transformation Working Group. The Children's Standing Committee Chair is a young consumer who has long received mental health services from Vermont's System of Care. The Adult Standing Committee Chair is Chair of the Planning Council. Among other Planning Council members who will serve on the TWG are the directors of Vermont Psychiatric Survivors, the Vermont Federation of Families for Children's Mental Health and NAMI-Vermont.

Most of the proposed TWG members from the Planning Council have served on one or both of the two planning committees that developed this proposal. They have all committed to serve on the TWG (see Letters of Support, Appendix 1) and fully understand that their role as TWG members will have a significant impact on Vermont's System of Care and thus their work on the Mental Health Planning Council and State Program Standing Committees.

C. APPROACH: STRATEGY

Consumer and Family Involvement in Application Preparation and in Vermont's Mental Health Transformation Plan Development, Implementation, Evaluation, and Sustainability

We developed this proposal through a highly collaborative process, including stakeholders representing constituencies from "cradle to grave," from the public and private sectors, from consumer and provider organizations, from mental health, public health, and a broad range of related services. Consumer and family leaders were fully involved from beginning to end. Our planning effort included two levels of group participation: a Stakeholder Advisory Group with over 30 invitees that met three times to develop the project vision and provide general guidance, and a smaller Transformation Grant Work Team of about a dozen people, that met weekly beginning mid-April to develop specific proposal components.

The directors of Vermont Psychiatric Survivors, (Vermont's statewide consumer group), NAMI-Vermont, and the Vermont Federation of Families for Children's Mental Health, as well as two young long-time mental health service recipients, along with the director of the Community of Vermont Elders, a consumer and advocacy group for older Vermonters, actively participated in the larger group. The first three were members of both planning groups, offering significant input into the proposal and recommendations from their constituent groups.

We appreciate, rely on, and *need* the strong consumer and family organizations that are vital partners in Vermont's mental health system. We undertake major policy, funding, program, and other decisions and initiatives only with active, ongoing consumer and family involvement. Vermont's policymaking State Block Grant subcommittees (the Standing Committee for Child, Adolescent and Family Mental Health and the Standing Committee for Adult Mental Health), similar standing committees for each Community Mental Health Center and the boards of Directors of CMHCS are comprised of at least 51% consumer and family membership.

Ensuring meaningful consumer and family involvement, true partnerships between consumers and providers, and respect for individual and family choices are guiding principles in both Vermont's *Blueprint for Health* and in the recent Vermont Agency of Human Services reorganization, both of which will be integrally involved with *Building Bridges.*

Building Bridges guarantees a vibrant consumer and family voice in Mental Health Transformation Plan development, implementation, evaluation, and sustainability through the following strategies:

1) *Strong representation on the Transformation Workgroup and a Working Group focused on Consumers and Families:* The directors of Vermont Psychiatric Survivors, NAMI-Vermont, and the Vermont Federation of Families for Children's Mental Health, and the Community of

Vermont Elders will all be TWG members. One of the *Building Bridges* workgroups, "Consumers and Families," will focus on full consumer and family involvement in both the mental health and physical health arenas, and will lead the way for a recovery and resiliency focus in both mental and physical health care.
2) *Hiring practices to promote consumers and family members as staff members:* The Field Specialist for the Consumers and Families workgroup will be a mental health consumer, and we will seek to hire qualified consumers and family members for other grant-funded positions. Position descriptions will include the statement that preference will be given to qualified consumers and family members (as provided for by Vermont state Human Resources policies), and we will undertake targeted recruitment efforts to develop a qualified pool of applicants.
3) *A significant statewide public education campaign:* Combating stigma, discrimination, and the persistence of attitudes that marginalize consumers and blame family members will be a major focus of the social marketing campaign that we fully expect will be a high priority for Vermont's Mental Health System Transformation plan. Consumers and family members will play active roles in designing, carrying out, and assessing the effectiveness of social marketing efforts.

Chair of Transformation Working Group Interface with Vermont's Governor and with Transformation Working Group Members to Ensure Transformation Activities Occur

Early on, Transformation Working Group (TWG) Chair Charlie Biss will meet with Governor Douglas, the Commissioner of Health, and the Deputy Commissioner of Mental Health. The governor has asked Health Commissioner Paul Jarris to be his lead representative on *Building Bridges.* Commissioner Jarris will serve on the TWG and provide a strong link between Charlie and the governor. The Deputy Commissioner of Mental Health reports directly to the Health Commissioner, which is a further rationale for selecting the Health Commissioner as the Governor's representative for this project. The Commissioner submits weekly reports to the governor, with verbal follow-up on key issues. Through this well-established working connection, Governor Douglas will have direct input into *Building Bridges* activities. Additionally, a schedule of quarterly briefings of the governor by Mr. Biss, who is well-acquainted with the governor, will be established.

TWG Chair Biss, who already has a close and positive working relationship with many proposed TWG members, will regularly meet with the TWG Executive Committee, comprised of the leaders of agencies and groups that are most vital to mental health system transformation. The Chairs of each of the six TWG workgroups will be selected from the TWG Executive Committee, ensuring strong communication channels. Charlie's assistant, the Project Manager, will be a seasoned administrator who will serve as another direct link to the six TWG Working Groups. The proposed Strategic Planner is a key position who will work closely with Charlie and the TWG Executive Committee as well as the six workgroups to help Charlie translate our vision for mental health transformation into reality, throughout the planning process and first two critical years of implementation. The proposed Continuous Quality Improvement (CQI) process, along with the evaluation effort (both described in Section F), will provide objective information to gauge the extent to which transformation activities are occurring and whether difficulties are arising that call for Charlie's attention.

Conduct thorough Needs Assessment and Inventory of Resources/Assets

This is addressed as Objective 2 under the next heading, *Develop Vermont's Mental Health Transformation Plan*, as it chronologically follows Objective 1 in plan development.

Develop Vermont's Mental Health Transformation Plan

GOAL: *Design and adopt a fundamental system transformation plan to ensure that Vermonters' mental health needs are addressed through robust and responsive organizational and delivery systems that are firmly grounded in the six goals of the New Freedom Commission, while tailored to Vermont's unique landscape and our vision for bridging the mental/physical health, public/private, and provider/consumer divides.*

OBJECTIVE 1: Create Project Structures and Functions (Year 1, months 1-3)

The structures and functions that we create will set the stage for developing and realizing Vermont's Mental Health Transformation Plan. We therefore describe in some detail our strategy for organizing the Transformation Working Group and positioning it for its vital planning, oversight, and implementation role in system transformation.

Hire Charlie Biss and Assistant (Project Administrator)

Upon notification of funding, Charlie Biss will resign his position as Director of Children's Mental Health and devote himself full time to staff recruitment (beginning with the Project Administrator) and project start-up. To ensure that he is in a central role with ready access to department heads and to the governor, Charlie will report directly to the Commissioner of Health, who leads the *Vermont Blueprint for Health*.

Convene Transformation Working Group and determine roles, relationships, and responsibilities

Transformation Working Group membership has been determined as part of this application process, as required. Chair Biss, with input from Governor Douglas and his designees, will create a TWG Executive Committee, ensuring strong consumer and family representation, inclusion of two *Blueprint for Health Executive Committee members,* and engagement with public and private initiatives pertinent to mental health system transformation. Under the leadership of TWG Chair Biss, the TWG Exec. Committee will create six workgroups:

- Consumers and Families
- Providers (workforce)
- Mental Health/Health Care Sector
- Communities
- Prevention/Public Health
- Information Systems

The TWG will approve the structure and determine workgroup objectives, tasks, timelines, use of current staff and other resources, and accountability. These workgroups reflect the six focus areas that drive the new Vermont State Health Plan model; they also closely align with the *Blueprint for Health* workgroups. Our intent is that through *Building Bridges*, mental health issues will be addressed on a par with physical health issues; creating workgroups that can partner as equals is a vital step in ensuring that this occurs. Overlapping membership and a mandate for collaboration and cooperation will ensure that the Blueprint and Building Bridges workgroups are strongly linked, to address mental health transformation holistically.

Vermont has the benefit of being a small state where most of the key players know each other and have worked together. The culture tends to be one of informality, where reaching across

organizational lines to collaborate is encouraged and ingenuity is rewarded. *Building Bridges* presents an ideal opportunity to make the most of these characteristic Vermont traits.

Develop structures and processes for regional Agency of Human Services (AHS), Department of Health, and CMHC, other providers, family and consumer group involvement

The TWG Executive Committee, led by Chair Biss, will institute formal processes and encourage informal channels for regional and local input and guidance. Vermont's 12 Public Health District Directors will serve as official liaisons between the corresponding 12 AHS regions and the TWG. They will work closely with the AHS Regional Field Directors and the regional structures designed to ensure cross-agency service integration and involvement of stakeholders in decision-making roles. The proposed *Building Bridges* staff will play a vital role in integrating regional and local activities and efforts, including those of CMHCs, with the Mental Health Transformation Plan development process.

Hire grant-funded staff and let qualitative evaluation/continuous quality improvement (CQI) contract

TWG Chair Biss will work with the Vermont Department of Human Resources, along with an *ad hoc* group of TWG members to hire qualified staff for the proposed positions (see Section E). The VDH business office and legal unit will carry out the required competitive procedures for the contract for managing the qualitative evaluation and the CQI process. The evaluation team, led by Team Leader John Pandiani, Ph.D. of DMH, will closely coordinate with Vermont's Mental Health Transformation plan design process, to ensure that CQI strategies are reflected throughout system change efforts and activities at every level.

OBJECTIVE 2: Expand Upon Needs Assessment and Inventory of Resources/Assets (Year 1, months 4-5)

Building on the preliminary Needs Assessment and Inventory of Resources/Assets included in this proposal, TWG Chair Biss and the TWG Strategic Planner will lead the following activities, in collaboration with the evaluation team:

- Review the preliminary Needs Assessment and Inventory of Resources/Assets included in this proposal and identify additional information needs.
- Identify and review relevant state and regional data collection efforts (research design and information collected) in mental health, physical health, and across human services.
- Design and carry out a process to gather state, regional, and local "best practices," current challenges/needs, and recommendations for strategies to address the challenges. Ensure use of methods to tease out issues related to cultural diversity and underserved groups, and strategies for consumer and family driven coordinated plans of care based on respect, resilience, and recovery.
- Design and implement a strategy to collect information still needed to ensure a comprehensive Needs Assessment and Inventory of Resources/Assets.
- Incorporate findings from these efforts and the preliminary Needs Assessment and Inventory of Resources/Assets into a final product to guide planning.

OBJECTIVE 3: Undertake a strategic planning process to guide and inform the Vermont Mental Health Transformation Plan (Year 1, months 6-9)

The Strategic Planner and TWG Chair Biss, along with other key staff, will lead a comprehensive strategic planning effort guided by our vision for mental health transformation. This effort will be carried out in the context of aligning Vermont's Mental Health Transformation Plan with *Blueprint for Health* principles and practices as we work towards New Freedom Commission goals. TWG staff will be instrumental to this effort, and TWG members will bring in staff from their agencies and organizations to offer assistance in their areas of expertise. Strategic planning will involve the following activities:

- Seek out, review, synthesize and make available to TWG members, staff and stakeholders information on current national system transformation initiatives, findings, and evidenced-based, emerging best, and values-based practices relevant to *Building Bridges* (e.g., the ADS Resource Center's Eliminating Barriers Initiative, the National Empowerment Center, NASMHPD's Mental Health Transformation Survey and Evidence-Based Practice Toolkits)
- Lead a statewide Best Practices Institute highlighting programs, policies and initiatives relevant to our needs and challenges for realizing the New Freedom Commission goals. The Institute of Healthcare Improvement Breakthrough Series model of learning communities for collaborative improvement (IHI, 2005), currently in use in Vermont through grant-funded activities within the *Blueprint for Health* is a promising model on which to base the Best Practices Institute.
- Hold 6 daylong strategic planning retreats with broad stakeholder involvement, one for each Building *Bridges* workgroup focus area, incorporating data and information from the Needs Assessment and Inventory of Resources/Assets and results of the Best Practices Institute. We will aim for these to produce ambitious recommendations to address Vermont's vision for mental health system transformation in terms of the 6 New Freedom Commission goals. One or more retreat may incorporate the Participatory Dialogue model (SAMHSA, 2000) as a strategy to encourage understanding, openness, and a collaborative planning process, especially with regards to full inclusion of consumers and family members.
- Bring results of planning retreats back to workgroups to synthesize and refine planning retreat recommendations, and then to prioritize them according to criteria set by the TWG.
- Publicize progress and results of planning steps through multiple media outlets, such as a newsletter, websites, and press releases, and solicit input from stakeholders and the public.

OBJECTIVE 4: Create and adopt Vermont's Mental Health System Transformation Plan (Year 1, months 10-12)

Led by TWG Chair Biss and the Strategic Planner, TWG members and staff will integrate recommendations into objectives and tasks to achieve them, addressing key issues such as formal MOUs, timelines, staffing, budgets, leveraging current initiatives and resources, and needed policy and legislative changes. We anticipate two major priorities will be 1) a pool of experts to provide training and technical and 2) a broad-based social marketing campaign. These initiatives will include some joint efforts with the *Blueprint for Health*. Activities will include:

- Develop mental health system transformation objectives, activities, benchmarks, key roles, and timelines based on priorities approved by the TWG.
- Determine the strategy to provide grant resources to AHS regions through the District Public Health offices for regional and local system transformation demonstrations – innovative pilot projects that respond to a particular area's mental health transformation priorities and challenges and are consistent with the New Freedom Commission goals.

- Describe the process for ensuring that providers work in partnership with consumers and families to create one individualized plan of care for each adult and child that is focused on respect, resilience and recovery, and integrating services and supports across systems.
- Once a draft plan is completed, provide the opportunity for review by the governor, Vermont's Mental Health Planning Council, and stakeholders, ensuring input by consumers, families, and groups with special needs (e.g., consumers with hearing limitations; consumers from minority populations; elders).
- Make revisions based on review, present for approval by the TWG, the Mental Health Planning Council and the governor, and adopt Vermont's Mental Health System Transformation Plan.

Linking Building Bridges with Other Grants and Organizing and Leveraging Current Activities, Staff, Funding, and Other Resources

We have deliberately organized the *Building Bridges* framework to align with Vermont's three most significant system change efforts: the Vermont Health Plan, which includes mental health, and the Health Plan's highly relevant focus areas; the *Blueprint for Health* and its cross-discipline, private/public, person-centered approach; and the Agency for Human Services reorganization to achieve goals similar to those of this initiative.

The Vermont Health Plan lays out a broad strategy for holistic health systems change in the state focusing on the five key stakeholder groups: individuals/consumers, providers, health care sector (systems), communities and public health; and, cross-cutting policy areas of prevention, access, quality, accountability and information systems. The plan specifically encompasses mental health and oral health in its goal of holistic change.

The Vermont Blueprint for Health is an initiative to improve the care of people with chronic conditions. It is organized around the five stakeholder groups of the Vermont Health Plan plus information systems. It is led by an Executive Committee made up of leaders in the public and private sectors. Workgroups for each of the stakeholder/focus groups include representatives of hospitals, primary care practices, community based organizations, voluntary organizations, consumers and others. The initial project is to improve diabetes care, but all interventions are designed to be readily adaptable to the full range of chronic conditions cared for by primary care physicians including depression, anxiety disorders and other mental health conditions.

The Agency of Human Services (AHS) reorganization creates exciting opportunities for *Building Bridges* to bring together mental health and health, public and private funders, and consumers and providers at the local level through the newly re-organized AHS regional structure. Through this reorganization, AHS has created a mechanism to decentralize authority, promote innovation and make programs more responsive to the needs of consumers. The structure for each District is as follows:

- *AHS Field Director* responsible for service delivery and development of innovative approaches for better customer service and outcomes in their region.
- *AHS Regional Leadership Team*, made up of the regional directors of all AHS departments and divisions and major contractors, including CMHCs, is charged with ensuring that services to individuals and families are better integrated and responsive.
- *Regional Advisory Councils.* Membership is made up entirely of service recipients of AHS agencies. In monthly meetings, the Advisory Councils provide consumer input and guidance to the AHS Field Directors

The 12 Districts also each have a *Regional Partnership,* "collaborative groups whose role is to develop and implement local strategies for improving the social well-being of Vermonters, to engage diverse community members as partners, and mobilize community resources to enhance local support services and systems to better achieve these outcomes (VT AHS, 2005)." Their focus is on involving community members who typically would not be involved in state government activities.

Other relevant statewide efforts include two AHS-led initiatives, the Vermont Alliance for Children, created to coordinate early care, health and education, and the Trauma Workgroup. Major federal and foundation grants such as Vermont's new SAMHSA SIG grant for co-occurring disorders and the RWJ-funded project on integrating depression treatment into primary care are other key activities that will involve the TWG and its workgroups.

Inclusion of key leaders from government, providers, public and private funders, consumers and families on the TWG ensures the authority to coordinate relevant efforts, staff and funding sources. Assignment of a staff member to each workgroup along with support from other TWG staff and partnering with the *Blueprint for Health* will provide the TWG with the necessary support to knit together strong, logical, and realistic integrated plans that include resources across agencies and funding streams.

The 12 District Public Health Directors, who are members of *Regional Leadership Teams*, will be the designated "point persons" for *Building Bridges* planning and implementation activities in their regions and the direct liaison between the TWG and the AHS regions. TWG staff will work with them and the AHS Field Directors to engage their regions' stakeholders, including consumers and families, in the needs assessment, strategic planning, implementation, and evaluation activities of *Building Bridges.* Public Health Directors will ensure that transformation occurs through a public health perspective, and is closely integrated with other health initiatives. The AHS Field Directors will bring in the broad range of mental health and human services stakeholders, consumers and family members whose participation is essential to mental health transformation.

Ensuring Individualized Plans of Care, Developed in Partnership with Consumers and Family Members

Individualized care planning for Vermonters with mental health needs ranges from highly effective to non-existent. *Building Bridges* provides the opportunity to build on the best of what we know works to provide consumers and families across the board with "a personalized, highly individualized health management program (President's New Freedom Commission, 2003)" that is consumer-led, coordinated across systems of care, and focuses on resiliency and recovery.

Vermont has excelled in implementing individualized, person-centered care planning for children and adolescents with severe emotional disturbance and their families and for adults with serious mental illness served through the publicly-funded mental health system. We have pockets of excellence elsewhere through pilot projects. But coordinated care planning in the private sector, in health care and other systems of care, and for people with mental health needs that are not severe are all areas of significant gaps and needs.

Vermont's System of Care Plan, codified into state law in 1988 as Act 264, required coordinated service plans for children and adolescents experiencing a severe emotional disturbance who need services from more than one agency. Since that time, Vermont has become a recognized leader in achieving coordinated plans of care with a "child-centered,

family-focused approach…based on a partnership between each child and his/her family" with the child and family the "decision-makers in this partnership (DDMHS, 2002)."

For adults with serious mental illnesses, the Wellness Recovery Action Planning (WRAP), a manualized self-management program developed by Vermonter Mary Ellen Copeland (Copeland, 1997) is in widespread use in Vermont and nationwide. Vermont Psychiatric Survivors leads five annual recovery education cycles through its SAMHSA State Consumer Network grant, and provides WRAP training for mental health agency staff and for consumers.

The collaboration between *Building Bridges* and the *Blueprint for Health* provides an ideal platform for broadening the reach of our successful models of individualized care planning to primary health care, to those at risk for developing serious mental illness, and to the privately-funded sector of care. WRAP's focus on individual self-management of recovery is congruent with the Vermont Health Plan and *Blueprint for Health* focus on consumer/patient self-management, active partnering with providers, and making informed choices about their care.

We anticipate that an early priority within Vermont's Mental Health Transformation Plan will be establishing a subcommittee of *Building Bridges* and *Blueprint for Health* workgroups to address the mutual goal of increasing the number of primary care physicians using coordinated care plans to treat both health and mental health conditions. Because the initial focus of the *Blueprint for Health* is diabetes, and depression is a common co-occurring condition, depression in diabetes will likely be the first focus of this collaborative effort.

Another opportunity ripe for application of the expertise we have developed is the AHS reorganization and its commitment to family-centered, strengths-based service planning, and to producing "one integrated and coordinated service plan that incorporates all individual agency/department service plans, and that has clearly defined accountability (VT AHS, 2005). The Division of Mental Health has recently embarked with AHS and the Vermont Department of Education on an effort to adapt the Interagency Coordinated Service Plan used for children and adolescents with severe emotional disturbance to children with all disabilities. We see great promise for expanding such collaborations as we work together towards mental health system transformation through *Building Bridges.*

D. APPROACH: SUSTAINABILITY

We are confident that Vermont's mental health system transformation vision and the fruits of our efforts to realize the vision will persist long after grant funding ceases. One key component is the structure of the grant itself, foremost the five-year system transformation period. Effective major systems change requires establishing new relationships, processes, funding streams, service delivery strategies, along with changing expectations and attitudes, none of which will occur quickly. The grant period allows ample time to create, test, assess, revise, and then adopt the new ways we will guarantee that Vermonters with mental health needs have access to a system of care that embraces New Freedom Commission goals.

The expectation of a comprehensive, thoughtful planning process involving the highest levels of leadership within state government, including the governor and state legislators, key public and private stakeholders, including consumers and families, is equally important to sustainable system transformation. We anticipate that the TWG will be an influential force throughout the implementation period, monitoring the process to ensure that system changes are realistic, and creating both better outcomes for consumers and opportunities for substantial savings sustainable

over time. Additionally, the following three factors each figure significantly in Vermont's ability to sustain our transformed system of care:

Demonstrated commitment to the need for and value of system transformation to improve the well-being and health of Vermonters

Vermont has already embarked on ground-breaking efforts to accomplish goals similar to those expressed by the New Freedom Commission, across systems and populations. Governor Douglas and administrative and legislative leaders, along with service providers, advocates and consumers and families, are collaborating to lead Vermont's major system change initiatives. Each reflects the understanding that significant improvements in the health and well-being of Vermonters will occur only with major system overhauls requiring a long-term perspective. These initiatives – the Vermont State Health Plan, the *Blueprint for Health,* the AHS Reorganization, the Global Commitment to Health proposal, and the governor's and state legislature's health care reform proposals – are all efforts that will have large impacts on Vermont's mental health system. Our design ensures that they will be integrated with *Building Bridges* strategies and that the changes we make through this initiative will be part and parcel of what can truly be called Vermont's movement for system transformation.

Building Bridges' focus on crossing the divide between health and mental health, private and public funders, and consumers and providers

We are approaching mental health transformation not as a series of steps to achieve our goals, but as a comprehensive, interconnected enterprise to create a different environment in which mental health care will be provided. Overcoming the traditional divides between physical and mental health, private and public funders, and consumers and providers is an exciting challenge with tremendous potential for lasting system change. Two-recently published reports from the Bazelon Center for Mental Health Law highlight the need for achieving this level of integration if we are to truly transform mental health care into a recovery-oriented system that takes a public health approach to prevention and early intervention, and ensures a single coordinated plan of care for consumers. (Bazelon Center, 2004; Bazelon Center, 2005). The reports describe both obstacles and promising strategies for attaining the kind of sustainable systems change that *Building Bridges* will work to achieve. *Building Bridges* will bring in the appropriate partners to focus and leverage Vermont's related system change efforts to bridge these divides – permanently.

A long track record of successfully sustaining grant-funded system change efforts

Vermont has received a number of a number of major federal and foundation grants that have supported major mental health system change over the past 20 years. Among the most significant are the six-year grant funded in 1993 as one of the first round of CMHS "System of Care" grants for children and adolescents with serious emotional disturbances; another six-year CMHS grant for early childhood mental health (1997) and the RWJ grant to downsize the Vermont State Hospital, transferring funds saved to community-based services (1987).

In each case, these grant initiatives promoted significant mental health system enhancements and changes that persist today. For example, the regional coalitions of child and family-serving organizations, advocates and consumers created as part of the CMHS system of care grant remain vibrant and active. The CMHS early childhood initiative provided significant training and

consultation resources which have changed practice throughout the state in vital areas such as responding to young children who have experienced trauma.

Our successfully sustained grant efforts share some common ingredients that are intentionally woven into the design of *Building Bridges*:

- A substantial training and technical assistance effort that changes not only what services and supports are provided, but also the "culture" of the system and attitudes of providers (for example, inculcating the understanding that parents are among the most important experts about what is best for their children with serious emotional disturbances).
- Assessment strategies that clearly demonstrate when the new service approaches, structures, and partnerships are both more efficient and more effective than what they have replaced (such as occurred with Vermont's CMHS-funded respite care initiative, which succeeded in establishing respite care as a mainstay in the publicly-funded service array, and the Vermont Consumer Network grants, which over the years have demonstrated that peer support both works and costs less than many other interventions).

SECTION E: APPROACH: STAFF, MANAGEMENT, AND EXPERIENCE

Dynamic Leader: Background and Abilities, Including Vision and Leadership Experience

Charles (Charlie) Biss, who has led the Child, Adolescent and Family Unit of Vermont's Division of Mental Health for the past 13 years, is an ideal candidate for the position of Transformation Working Group Chair. Mr. Biss is both the hands-on director of a large and complex state-funded system with multiple activities and providers serving 10,000 children a year, and a visionary leader, whose expertise in planning, implementing and sustaining far-reaching system reform in children's mental health is recognized far beyond Vermont. Mr. Biss has been a driving force in Vermont's renowned success with including families as partners in systems of care. His core values of inclusiveness, strengths-based, family-centered care are evident in every aspect of Vermont's system of care for children and adolescents with severe emotional disturbance and their families. Charlie was instrumental in helping Vermont's Agency of Human Services redesign its systems and policies to better reflect these values in its recent reorganization. Individualized service planning that responds to the diverse needs of children and their families is one of Charlie's mantras; we are confident that our transformed system of care under his guidance will include individualized and coordinated plans of care across systems and funders. As a national consultant with Georgetown University's National TA Center for Children's Mental Health and with the Federation of Families for Children's Mental Health, Mr. Biss guides other states through the difficult challenges of incorporating these values into practice through their SAMHSA/CMHS Comprehensive Community Mental Health Services for Children and their Families grants. Mr. Biss led this 5-year systems change grant in Vermont, as well as a more recent 5-year SAMHSA/CMHS grant that focused attention on the mental health needs of children from birth to age six and their parents, and increased understanding of prevention as a priority. A great tribute to Charlie's leadership is that he has crafted agreements with Vermont's legislature, governor, and other top leaders, including legislative changes and leveraged funding, that have ensured that the far-reaching impacts of these and other major grant-funded efforts, such as for respite care and transition services, are sustained long after the grants end.

Mr. Biss is widely respected throughout our state for reaching beyond organizational lines, seeking new ways to make connections that meet children's and families' multiple needs and work for agencies as well. Just two of these unique and potent efforts are Vermont's Success

Beyond Six program, providing school-based mental health services through Vermont's CMHCs, and the Pediatric Collaborative, a pilot project that brings social workers into pediatricians' offices to work with children and their families, and to cross-train staff. Charlie has significant experience leading adult mental health initiatives as well. In the early to mid-1980s, he developed and led psychoeducational groups for family members of people with mental illness, which led to the founding of NAMI-VT. From 1987-1993, Mr. Biss directed Vermont's major RWJ-funded project, which downsized the Vermont State Hospital from 250 to 60 beds by creating diverse and innovative community programs, transferring funds saved from ward closings to the community. Charlie was also a founding board member of Vermont's largest homeless provider, the Committee on Temporary Shelter (COTS). Charlie Biss is that rare combination: a dynamic risk-taker able to create shared visions and galvanize people into action, who is also a seasoned realist who personally understands the real-world challenges that leading transformational change presents. We are most fortunate to have someone of Mr. Biss's caliber, skills, temperament and deep Vermont experience chair our Transformation Working Group.

Mr. Biss is highly respected by colleagues and stakeholders throughout Vermont. However, he was unable to commit to this position until after letters of support for *Building Bridges* had been solicited and received.

Members of the Transformation Working Group

Vermont will use the overall Transformation Working Group to ensure inclusion of a variety of stakeholders. As such, the TWG will have over 40 members, necessitating the need for a TWG Executive Committee to complete specific work tasks as needed. Due to page limitations, this list only includes members of the Executive Committee—see Appendix 1 for letters of commitment from all participating members. As evidence of their commitment to MH transformation, all individuals listed here have supplied a letter of commitment (see Appendix 1)

Name	***Role***	***Level of Effort***	***Qualifications***
Charlie Biss	Chair	100%	See description above
Paul Jarris	Act as Governor's Office Liaison, Provide direction re: policy development, implementation and political leadership	5%	Current Commissioner of Dept. Of Health; Medical Director for Vermont's largest nonprofit HMO responsible for quality improvement, resource management, practice relations, and medical affairs; President/CEO of Vermont Permanente Medical Group and CEO of Primary Care Health Partners, Vermont's largest statewide primary care medical group
Paul Blake	Provide leadership with policy development, with focus on mental health promotion, prevention, and treatment	10%	Acting Deputy Commissioner of Mental Health 20 Year career in MH as provider and state leader during Vermont's transformation from hospital to community-based system
Beth Tanzman	TA re: adult MH system of care	10%	Director of Adult Community Mental Health Services, Division of Mental Health, Nationally recognized state program director in areas of implementing and supporting innovations in public mental health system
To be hired	TA re: children's MH system of care	10%	Director of Child, Adolescent and Family Unit, Division of Mental Health
Susan Besio	Link with AHS Secretary's Office and Strategic Planning	5%	Director of Planning, Agency of Human Services, Former Commissioner of Department of Mental Health

Liz Reardon	Link with state Medicaid Office, TA re: linking mental health and physical health	8%	Managed Care Director, Office of VT Health Access Principle Investigator, VT Community Depression Project Director, Best Clinical and Admin. Practices Project for Adults with Disabilities.
Cathleen Voyer	Link with state housing and transportation policies and needs	5%	Director, AHS Housing and Transportation Chair, Vermont Interagency Council on Homelessness
Diane Dalmasse	Represent State vocational rehabilitation interests, TA re: expanding employment opportunities	5%	Director, Division of Vocational Rehabilitation Provided state level leadership in increasing access to supported employment and benefits management for consumers
Cynthia Wolcott	Link with state child welfare and juvenile justice	5%	Deputy Commissioner, Family Services Division, Department for Children and Families, 27 years experience in child welfare system
Susan Onderwyzer	Link with criminal justice system	5%	Program Services Executive, Department of Corrections, 20 years experience as MH and Substance Abuse Counselor, Administered several statewide mental health programs
Peter Albert	Representing Private Insurers and privately funded MH providers	5%	Director, PrimariLink (Managed Service Organization of Retreat Healthcare), manages mental health needs of thousands of VT residents with MVP Insurance, Licensed clinical social worker, 27 years
Marty Roberts	Consumer representative, TA re: recovery education and empowerment, representative of Vermont Psychiatric Survivors	5%	Chair, State Block Grant Planning Council, Certified Recovery Educator, national presenter on recovery education, chair of Washington County Mental Health consumer advisory committee, co-coordinator of "Moving Ahead" project (see section A)
Clare Munat	Family and NAMI-VT representative, TA: on family involvement and education	5%	Co-Chair of Adult Mental Health State Standing committee, member of State MH Block Grant Planning Council, NAMI-VT educator and support group leader, president of NAMI-VT board
Dan Fisher	Consultant re: MH transformation, New Freedom Commission	4%	Executive Director of National Empowerment Center, member of New Freedom Commission on Mental Health
Michael Hartman	Representative of community MH providers	5%	Director of adult mental health services of Washington County Mental Health, state leader in promoting and implementing recovery education, consumers as providers, and intensive community-based services
Kathy Holsopple	Family and VT Federation of Families representative	5%	Executive Director of VT Federation of Families, member of Children's MH State Standing Committee and State MH Block Grant Planning Council, 6 years experience as family resource specialist
Zachary Hughes	Youth representative	5%	Chair of Children's Mental Health State Standing committee, member of State MH Block Grant Planning Council, experience as youth receiving mental health services
Senator James Leddy	Legislative representative	5%	Chair, VT Senate Health and Welfare Committee, Former Executive Director of Community Mental Health and Substance Abuse Treatment center

Staff Working Under Direction of Transformation Working Group

The Transformation Working Group chair and members are charged with leading an effort that calls for them to "formulate and communicate a unique vision for the future, offering the

needed support and providing the essential visionary and operational direction (SAMHSA, 2005)." To realize our vision for system transformation, we have carefully designed the staffing plan for *Building Bridges* to ensure the right balance of content experts and administrative staff who will complement the roles and experience of the TWG and carry out much of the crucial coordination and management work as well as provide specialized expertise in key areas. All staff positions are full time equivalents, unless otherwise noted.

Charlie Biss, Dynamic Leader, will lead the Transformation Working Group and the project staff. This is a full time commitment for the five years of the grant period. Mr. Biss will convene and lead Transformation Working Group meetings, and will head the TWG Executive Committee that will make key policy and planning decisions. Charlie will set overall policy direction, convene working groups, ensure that planning, implementation, and evaluation processes for Vermont's Mental Health Transformation Plan meet major milestones, and supervise and provide direction to the project staff. TWG Chair Biss will interface directly with the Commissioner of Health, Paul Jarris, and with the Honorable James Douglas, Governor. Charlie will represent Vermont at project national meetings and in other national forums.

Project Administrator (Assistant): This yet-to-be-hired position will work directly with TWG Chair Biss and providing overall project coordination. We will recruit for an experienced administrator who has significant experience in the management and organization of large, multi-focus projects. The administrator will oversee the development of all written communications for the project, coordinate the overall staffing for the project, and provide staffing assistance to the Transformation Working Group. In addition, the project administrator will ensure that the local and regional level work is well coordinated with the state-level efforts.

Prevention Specialist: This yet-to-be-hired position will be responsible for designing and overseeing the prevention and early intervention initiatives for Vermont's Building Bridges Transformation project. The Prevention Specialist will staff the *Building Bridges* workgroup on Prevention/Public Health and integrate *Vermont Blueprint for Health* prevention efforts and initiatives with *Building Bridges*, using the Prevention/Public Health Workgroup as a collaborative forum. Key responsibilities will include designing prevention initiatives specific to children and families, adults, and elders, including specific groups with cross-cutting needs, as well as those from diverse backgrounds and cultures, and working closely on the design and implementation of the social marketing campaign to broaden awareness of mental health promotion and prevention of mental illness and promote access to early identification and treatment, with a focus on lowering risks and increasing protective factors, especially for children and families. The Vermont Department of Health will provide in-kind support to the Prevention Specialist by convening a cross-cutting peer group that includes prevention specialists working in our Tobacco and smoking prevention initiatives, alcohol and substance abuse prevention specialists in Vermont schools, and key public health professionals working in VDH's District offices including from the WIC and immunization programs.

Public Education Coordinator: This yet-to-be-hired position will be responsible for the *Building Bridges* project social marketing campaign to end stigma and discrimination, promote mental health as a health issue, promote access to early identification and treatment, as well as creating broad awareness and understanding of consumer-directed recovery and resiliency. This individual will draw on the fields of marketing, prevention, and health care. He/she will oversee the contract to develop a sequential and broad approach to public information so that Vermonters recognize the early signs of mental disorders, know how to access early stage treatment and support, and so our communities support and welcome all citizens.

Communications Specialist: This yet-to-be-hired staff will be responsible for ensuring regular communication between the state and local planning groups, the Transformation Working Group and its workgroups and the cross-cutting Blueprint framework groups (illness management, community activation, provider practices, and information technology). This position will develop and staff a project Web page, weekly updates to the stakeholder community, press releases, and will cultivate a working relationship with the major media outlets in Vermont to place positive stories about resilience, recovery, and effective treatment. To support innovation, this position will seek out new approaches that regions and communities are taking and broadly communicate these key learning's to the entire stakeholder community.

Field Specialists: Five, full time program specialists will be hired to staff and coordinate five of the *Building Bridges* workgroups (in addition to the Prevention Specialist, who will staff the Prevention/Public Health workgroup). VDH will actively recruit among the mental health consumer and family communities for these positions. At minimum, the Consumers and Families Field Specialist will be a consumer or family member. One staff each will be responsible for convening, organizing, reporting and generally supporting the following work groups: 1) Consumers and Families,) Providers, 3) Mental Health/Health Care Sector, 4) Communities, and 5) Information Systems. The field specialists will also work closely with the partnerships at the community level and coordinate with the Strategic Planner (below) to complete the needs assessment, develop action steps and tasks, and carry out transformation activities.

Strategic Planner: A full time position will be hired to work with the TWG Chair to establish the overall framework for the needs assessment and Vermont's Mental Health Transformation Plan development. He or she will coordinate planning efforts among TWG workgroup members and staff, as well as regional Department of Health/AHS involvement, and will be the primary writer. Following adoption of the plan, the Strategic Planner will provide expertise to make sure that Vermont's Mental Health Transformation Plan action steps and tasks translate into system transformation at the state, regional, and local levels. This position will assist the Transformation Working Group and the workgroups, to develop clear written plans for their work, and coordinate them with the *Blueprint for Health,* other Department of Health initiatives, AHS state and regional planning, and federal and other grant resources. This position will be full time for three years, spanning the development and completion of the planning phase and first two years of implementation of *Building Bridges*.

Fiscal Design Specialist: This full-time position (to be hired) will assist in developing the inventory of public and private funding streams that support provision of mental health care in Vermont. The position will also assess the strengths and limitations of the various billing systems in use and develop recommendations for the TWG and Chair about how these could more efficiently interface to streamline billing for practitioners and assure appropriate sub-recipient monitoring for payers. The Fiscal Design Specialist will help design and implement financial system improvements that support mental health system transformation strategies.

Diversity Leader: The Vermont *Building Bridges* project will support 20% of the Department of Health's Office of Minority Health Coordinator. Working closely with the project staff and TWG, this staffer will help ensure that diversity and cultural competence are embedded in all project activities. This position will assist in bringing minority stakeholders to project teams, work groups, and events to help developing, implementing, and assessing Vermont's Mental Health Transformation Plan. In addition, the Diversity Leader will interface closely with the Communication Specialist and Public Education Coordinator to ensure that critical

perspectives of diversity and culture are well represented in our education approaches and communications plans.

Administrative Assistant: A full time administrative assistant will be hired to provide secretarial support to the Transformation Working Group. The administrator will prepare mailings, maintain communications provide administrative support to project meetings, and help organize training and technical assistance events.

John Pandiani, Ph.D., Chief MH Research and Statistics: Twenty percent of Dr. Pandiani's time will be dedicated to the project. He will supervise the development and implementation of the outcome evaluation, assist in the design and oversight of the process evaluation (this component will be contracted for), supervise the Research and Statistics Analyst positions and coordinate, with the IT section, the work of the Data Coordinator IT Specialist.

Research and Statistics Analyst: Two full time to-be-hired position will be responsible for generating regular analytical reports on the required outcome measures and for the project evaluation. These reports will also create a feedback loop to improve the accuracy and comprehensiveness of data reported to our numerous systems. In addition, the analysts will assist in the production of reports that cross databases (e.g. Hospital Discharge Data Set, criminal justice reporting, employment data, Medicaid claims processing data, MH service encounter data etc.) project reports, and for staffing the reporting on the required outcome measures.

Data Coordinator IT Specialist: This full time position will be responsible for inventorying the contents and capabilities of the multiple data bases involved in the treatment, reporting, and oversight of mental health services. After completing the inventory, this position will work with the dynamic leader, transformation working group, and Dr. John Pandiani to identify the most critical information gaps in our information systems to sustaining the transformation project. In concert with policy leaders, the Data Coordinator will design plans to assure the efficient interface of existing systems to implement the transformation project plans including the necessary upgrades in IT systems and software acquisition.

Involvement of Other State Staff in Building Bridges

In addition to the Building Bridges Staff outlined above, and the State staff referenced as members of the Executive Committee of the TWG, other state staff will serve on the TWG and assist in the implementation and coordination of grant activities:
The following Vermont Department of Health leaders will contribute 8% of their time:
Barbara Cimaglio, *Deputy Commissioner of Alcohol & Drug Abuse Programs*; Policy development direction, especially regarding substance abuse prevention, promotion and treatment
Sharon Moffat, *Deputy Commissioner of Health*: Direction and technical assistance regarding public health prevention, promotion, and treatment
Patricia Berry, *Director, Community Public Health Programs*: Supervision and direction of District Health Directors with community-wide resource inventory and needs assessments and help with linking with the AHS regional structure to plan and carry out regional and local system transformation activities

At the Agency of Human Services (AHS) level, Steve Dale, *Deputy Commissioner of Field Services for AHS*, will contribute 5% of his time to supervising the 12 regional Field Service Directors in their mental health transformation planning, implementation and assessment activities.

At the regional level, the 12 District Health Directors and 12 Field Service Directors will each provide a 5% in kind commitment to coordinating and leading *Building Bridges* activities within regions and local communities. The District Health Directors will be the direct link between the TWG and its 6 Working Groups, while the Field Service Directors will be responsible for coordinating *Building Bridges* efforts with the Regional Leadership Teams of managers, the Regional Partnership Teams of providers, advocates and other stakeholders, and the Regional Advisory Councils of service recipients of AHS agencies.

Additional staff within AHS will be called on for their specific expertise as warranted on an ad hoc basis, as well as staff in other agencies representing relevant interests on the TWG, such as housing, education, and veterans.

Technical Assistance, Consultation, and Training Experts

Building Bridges will provide for content-specific training and consultation. Dr. Daniel Fisher, member of the President's New Freedom Commission and nationally recognized leader in mental health systems transformation - will orient our stakeholder community to the transformation process nationally and provide expertise on building bridges between consumers and providers. Dr. Steven Banks will consult on data systems development and statistical analysis and share his expertise in helping diverse stakeholder groups reach consensus about outcome measurement frameworks. Dr. Banks' familiarity with the SAMHSA data infrastructure development initiatives will help ensure that *Building Bridges* appropriately leverages other project activities. We also plan to contract early on with the Center for Women, Violence and Trauma, whose nationally-recognized experts regularly work with states to help develop trauma-informed approaches to behavioral health and health care provision. The Training and TA pool will allow us to contract with other national experts in the areas of public health, coordination with primary care, suicide prevention among the elderly, expertise on cultural and ethnic diversity, and so forth.

Building Bridges – Year 1 Timeline

Objective	Months	Key Staff	Milestones
1. Create Project Structures/Functions	1-3	TWG Chair Project Administrator Commissioner, VT Dept. of Health Deputy Commissioner, Div. of Mental Health	**Month 1** Hire TWG Chair and Administrator **Month 2** Convene TWG; determine roles/responsibilities; set up workgroups, including integration with *Blueprint for Health* **Month 3** Develop structures and processes for regional/local involvement **Month 3** Hire grant-funded staff and let process evaluation contract
2. Expand Needs Assessment and Resources/Assets Inventory	4-5	TWG Chair Data Coordinator/IT Specialist Fiscal Design Specialist Evaluation Team Leader	**Month 4** Review preliminary Needs Assessment/Resources Inventory; identify additional information needs **Month 4** Identify & review state, regional, local data collection efforts **Month 4** Gather "best practices," challenges/needs, recommended responses to meet needs **Month 5** Design and carry out strategy to collect data/information for comprehensive Needs Assessment & Resources/Assets Inventory **Month 5** Incorporate findings into final product to guide planning

3. Undertake Strategic Planning Process to Guide Plan Development	6-9	Strategic Planner Project Administrator Fiscal Design Specialist CQI/Process Evaluator TWG Chair Prevention Specialist Communication Specialist	**Month 6** Seek out, review, synthesize & share initiatives, practices, strategies relevant to mental health transformation **Month 7** Hold Best Practices Institute **Months 7-8** Hold 6 Strategic Planning Retreats; 1 for each workgroup focus **Month 9** Create recommendations for MH Plan prioritized by TWG criteria **Month 9** Publicize progress and seek input from stakeholders and public
4. Create and Adopt Vermont's Mental Health Transformation Plan	10-12	Strategic Planner TWG Chair Fiscal Design Specialist CQI/Process Evaluator Prevention Specialist Deputy Commissioner, Div. of Mental Health	**Month 10** Develop MH Plan objectives, activities, benchmarks, roles, timelines **Month 10** Determine strategy to allocate grant resources for regional/local pilots **Month 10** Create process to ensure plans of care coordinated across systems **Month 11** Develop draft MH Plan for review by governor, Mental Health Planning Council, stakeholders **Month 12** Make revisions, present for approval and *adopt Vermont's Mental Health Transformation Plan*!

F. EVALUATION AND DATA

Our mental health system is well positioned to address issues of accountability and continuous quality improvement. Vermont's Performance Indicator Project (PIP) provides an excellent framework from which to build a comprehensive approach to evaluation and continuous quality improvement. The Performance Indicator Project began in 1997; in February 1999 a Multi-Stakeholder Advisory Group, including consumer and family members, was convened to identify key indicators of mental health program performance, including treatment outcomes, access to care, and services provided. The ongoing process includes regular distribution of reports and periodic face-to-face meetings with stakeholders. The Performance Indicator Project is designed to promote a culture that supports rational data-based thinking and decision-making among providers, consumers, and advocates in Vermont. Weekly reports and periodic summaries are available at www.ddmhs.state.vt.us/docs/res-eval/pip-reports.html.

Vermont's Current Data Collection Resources/Approaches

As of 1992, all state-funded community mental health programs submit electronic Service Reports to DMH on a person and encounter specific basis, using a state designed common format. Financial data includes revenues and expenses by category at the cost center level, and assets and liabilities at the organizational level. Human resource data is at the individual staff level. The Research and Statistics Unit gathers, analyzes and reports on these data from community-based providers, the Vermont State Hospital, designated inpatient units, other Agency of Human Services programs, and other state, federal and private entities. We designed effective and efficient systems to integrate data across local and state levels and a variety of agencies. Cross-agency data analysis is facilitated by the use of Probabilistic Population Estimation, a statistical methodology providing unduplicated counts of the number of individuals served by multiple agencies, without reference to personally identifying information.

Evaluation Design

Our evaluation design builds on the Performance Indicator Project, using both quantitative and qualitative data to evaluate *Building Bridges* and the larger system of care, and to inform a continuous quality improvement process for the project. The evaluation design involves:

1. Outcome: Tracking SAMHSA National Outcome Measures (NOMs) and Vermont outcome measures which assess achievement of the New Freedom Commission goals as well as the three key *Building Bridges* transformation goals:
    a. Bridging physical/mental health systems
    b. Bridging consumer/provider divides
    c. Bridging public/private systems and funders
2. Performance: Use of GPRA indicators to assess implementation of Vermont's Mental Health Transformation Plan.
3. Process: Documentation of activities and the degree to which objectives are accomplished. As part of the process evaluation, we will identify strategies that are working well, emerging challenges and possible new approaches.

OUTCOME EVALUATION

Our outcome evaluation will include the SAMHSA National Outcome Measures (NOMs) and the CMHS Uniform Reporting System measures. Current data collection systems are in place to allow tracking these outcomes annually over the five-year grant period. Specifically:

1. Decreased mental illness symptomatology – Community mental health centers report annual Global Assessment Functioning (GAF) scores for clients. Since there are significant concerns in Vermont about the reliability and applicability of GAF to all populations, the evaluation team will work with the Multi-Stakeholder Advisory Group to explore other measures applicable to a range of populations. Addressing the utility of symptomatology or functioning measures will be part of this effort. We will identify useful measures pilot test and then develop methods to incorporate these measures into the DMH tracking system.
2. Increased or retained employment and school enrollment – Quarterly, DMH links client data with Department of Employment and Training employment data (Pandiani, Tracy, Simon et al. 2004). School enrollment and performance is tracked using the Department of Education achievement test score data base.
3. Decreased involvement with the criminal justice system – DMH tracks clients through criminal justice system databases, including State Police, courts, and Department of Corrections. We have done comparisons of pre- and post-treatment levels of criminal justice involvement (Pandiani, Banks, & Schacht, 1999; Pandiani, Banks, Clements et al., 2000; Pandiani, Banks & Pomeroy, 2003).
4. Increased stability in family and living conditions – Annual data collection from community mental health agencies includes clients' living situation. We also use HUD data in conjunction with DMH data time to determine stability (Pandiani & Morabito, 2004).
5. Increased access to services/number of persons served by age, gender, race and ethnicity – This has been a major focus of our ongoing evaluation efforts and includes use of data gathered through monthly Service Reports. (Pandiani, Banks, Bramley, et al., 2002; Pandiani, Banks, Bramley, et al., in press).
6. Decreased utilization of psychiatric inpatient beds – DMH has psychiatric in-patient data for general hospitals, private psychiatric hospitals, Vermont's Veteran's Administration hospital and Vermont State Hospital for over the past ten years (Banks & Pandiani, 1998).

7. Increased social support/social connectedness – As we currently have no clear data for this outcome, the evaluation team will be charged with identifying potential measures, in collaboration with the Multi-Stakeholder Advisory Group, and then pilot use of measures.
8. Increased positive reporting by clients about outcomes – DMH conducts regular consumer surveys to assess satisfaction with both children's and adult services (Pandiani, Schacht & Banks, 2001); also see www.ddmhs.state.vt.us/docs/res-eval/satisfaction-research.html. As part of this evaluation, Community Rehabilitation and Treatment (CRT) clients are also asked to assess their outcomes. (See Appendix 2 for copies of these instruments.)
9. Increased cost effectiveness – DMH has the capacity to assess cost effectiveness using a variety of outcome measures and service expenditures.
10. Increased use of evidence-based practices – DMH can track the number of clients served in various programs (Banks, Pandiani, Simon et al., 2005; Banks & Pandiani, 2001). Moreover, the Mental Health Clinical Advisory Panel will be evaluating evidence-based, promising, and values-based practices and will be able to provide information on pilot projects and more widespread implementation.

In addition to the National Outcomes, *Building Bridges* will expand upon the existing Vermont Indicators of Mental Health Program Performance outcome measures, as follows:

Identify relevant outcomes: An important element of the mental health planning process will be identifying specific changes expected to occur as a result of achieving each Mental Health Transformation Plan objective. Building on the Multi-Stakeholder Advisory Group, we will review current outcome measures as we translate desired changes into specific, measurable indicators used to define outcomes. Outcomes will reflect changes expected when bridges are built between:

- Public/private systems and funding
- Mental/physical health
- Consumers/providers

At the systems level, for example, we may seek to assess levels of access to care, practice patterns and treatment outcomes across public and private funding. We have the technology to provide unduplicated counts by type of services and expenditures. In addition, we will focus on outcomes consistent with the IOM definition of quality of care (Daniels & Adams, 2004): that is, the service system provides (a) safe, (b) person-centered, (c) effective, (d) timely, and (e) equitable care. A measure of person-centered care, for instance, would be documentation of an individualized, integrated plan of care for each person served in the mental health system.

Looking at more person-centered outcomes, we can track measures related to risk and protective factors (e.g., youth assets such as feeling valued by one's community). The Agency of Human Services has been tracking a range of risk and protective factor measures for Vermonters throughout the lifespan as part of annual Community Profiles (www.ahs.state.vt.us/04ComPro/). The Office of Child, Adolescent and Family Mental Health has identified four primary quality domains, with specific outcomes for each. This framework will be helpful in identifying specific outcomes relevant to youth and families.

Outcomes will be defined to monitor the overall *Building Bridges* aims (i.e., bridging public/private, mental/physical health, and consumer/provider divides) as well as specific aims for each Mental Health Transformation Plan objective. We will examine outcomes relevant at the local, regional and state levels, identifying specific outcomes that might be most relevant at each level and outcomes that can be assessed and reported across each level.

Develop outcome measures: While most outcomes identified through this process will have existing data sources, we will also develop new measures as needed. Using the *Blueprint for Health* experience and knowledge, we will develop or adapt measures which can be used across both public and private sectors and for mental health services provided by primary care physicians and in other medical settings.

Collect and manage data: As part of the PIP process, the Research and Statistic Unit gathers and manages outcome data. This system includes web-based reporting from community service providers and the Vermont State Hospital. Recently, the Research and Statistics Unit developed strategies to gather and manage data across public and private sectors, collaborating with VDH as part of an assessment of unmet need for HIV/AIDS related medical procedures. Most major private insurers in Vermont participated in this assessment. We will look to this promising model as we expand the PIP Process to include health-related data and data from private insurers.

Analyze data: Continuing the PIP model, data will be analyzed regularly to assess achievement of outcomes at local, regional, and state levels. Outcome measures will be specifically analyzed by age, ethnicity/race, and other salient population categories.

Report data: As with other PIP reports, regular user-friendly reports linking activities and outcomes will be distributed widely and posted on the website for review by stakeholders at regional and state levels. Through *Building Bridges* and its collaboration with the *Blueprint for Health*, this stakeholder group will be expanded to include health related and private insurers as part of the PIP process. Our PIP effort was recognized by the Annapolis Coalition on Behavioral Health Workforce Education as an "Innovative Educational Practice" and will be highlighted in a forthcoming special issue on *Administration and Policy in Mental Health.*

PERFORMANCE EVALUATION:

Building Bridges will use the GPRA infrastructure indicators to assess implementation of the Mental Health Transformation Plan. During Year 1 of the project, we will collect baseline data and then develop specific targets based on these data. To gather baseline information on policies, organizational structures, and practices, the evaluation team will conduct structured interviews with key stakeholders at agency, regional and state levels.

Upon adoption of the Mental Health Transformation Plan, the evaluation team, working with the TWG, will identify areas in which to track policy, organizational and practice changes targeted by the Plan. An annual stakeholder structured interview will include questions about these identified changes. All new state-level policies are posted on Department websites; the evaluation team will track policy changes monthly and compile an annual summary.

We will track training performance using three methods:

1. Annual survey of all providers in mental health, health and related systems requesting information on the number of staff attending training specific to the service improvements and practice changes recommended by the Plan. The survey will assess details on training (e.g., sponsor, length, available CEUs, etc.) and staff who participated (e.g., proportion of staff attending, direct care staff, management staff, etc.).
2. Track new training programs offered statewide and regionally – An evaluation team member will monitor AHS departments' sponsored training and regionally/locally offered training (using AHS/VDH districts and regional partnerships to monitor).
3. Track proportion of consumers and family members who are included as trainers, lead training activities and who are included as peers with professionals as training audiences.

Structured interviews with key stakeholders will help us assess current data collection systems at the agency, regional and state levels. We will review summaries of data provided by community-based agencies and other entities, and ask for input on accuracy and usefulness. We will also ask for feedback on the current distribution of reports used in the PIP process. The initial set of interviews will provide a baseline. Following adoption of the Mental Health Transformation Plan, the evaluation team will identify data relevant to Plan objectives and compare to baseline information on type and quality of data currently tracked. As part of the annual structured interviews, we will identify any new data collection and/or strategies for analysis and use introduced at agency, regional, and state levels.

Working with statewide consumer and family-run organizations, including NAMI-VT, Vermont Psychiatric Survivors, Vermont Federation for Children and Families, and the Community of Vermont Elders, we will determine membership levels at the time *Building Bridges* is initiated. We will annually gather data on membership increases and decreases within individual organizations and across all organizations. We will also develop a process to track new consumer and family organizations developed during the course of the grant.

PROCESS EVALUATION:

The process evaluation will monitor implementation of the project objectives. Information gathered through the process evaluation will also be used to inform the continuous quality improvement process. Data will be gathered through surveys and structured interviews, as well as documentation of activities.

Building Bridges is designed to ensure that all stakeholders, particularly consumers and family members, have meaningful roles throughout the mental health system transformation process. Not only do we want to assess stakeholder involvement in the project, we will seek stakeholder input to monitor project developments, accomplishments and challenges. As part of the process evaluation, we will include the following methods involving stakeholders:

1. Structured interviews of key local, regional and state stakeholders, including consumer and family statewide leaders and local representatives, Transformation Working Group (TWG) members, *Blueprint for Health* Executive Committee members, Department of Health District Directors, AHS Regional Field Directors and Leadership Teams, AHS Regional Partnership members, CMHC and other community-based service providers, primary care and other medical care providers. Initial Interviews will be conducted early on as part of the comprehensive needs assessment and to establish baselines for performance and process measures. Thereafter, annual interviews will be conducted. The interviews will gather process information to monitor implementation, progress, and challenges with the *Building Bridges* project. Some performance data will also be gathered. Questions will include perceptions of meaningful involvement in *Building Bridges* and recommendations for action.
2. An annual survey of consumers, family members, and other key stakeholders involved in *Building Bridges*. Survey questions will be designed with significant input from consumers and family members to assess the level of involvement and satisfaction with process, as well as recommendations for improvements.
3. An annual survey to assess participation of providers in systems outside of mental health in training, use of new tools and collaboration with mental health providers in serving clients. We will survey providers across a range of systems, including elder care, primary health care, corrections, domestic violence and rape crisis centers and other community providers. Consumers and family members will assist in survey design and identifying provider groups.

The first survey will be conducted immediately upon Plan adoption to provide a baseline measure. Follow-up surveys will be conducted in Years 3, 4 and 5 to assess progress.

In addition, we will document accomplishments specific to the project objectives. Examples of specific data to be collected include:

Objective 1: Project Structure and Functions

- Written outline of roles and responsibilities for Transformation Working Group members, staff and workgroups.
- Written outline of working relationships between Transformation Working Group and *Blueprint for Health* Executive Committees and workgroups.
- Written outline of roles and responsibilities of regional AHS/VDH, regional partnerships.
- Communication systems between Transformation Working Group, regional groups, and stakeholders in place, including regularly scheduled meetings, written communications (e.g., newsletter).
- Sign-off process in place for adoption of new polices, structures, relationships.
- Written description of lines of accountability and mechanisms to ensure adherence.

Objective 2: System Assessment: Assets/Needs Assessment and Inventory of Resources

- Methodology (including all participants) to conduct system assessment (Needs/Assets Assessment and Inventory of Resources) finalized. Incorporate items to address GPRA indicators on policy, organizational structure, and practices.
- Written report summarizing system assessment methods, results, and conclusions.

Objective 3: Strategic Planning Process

- Written summary of each strategic planning retreat, summarizing findings and recommendations, identifying participants.
- Written summary of Best Practices Institute proceedings, including participants, vision, findings and recommendations.

Objective 4: Create and Adopt Vermont's Mental Health Transformation Plan

- Written summary of process used to determine statewide system transformation objectives, as well as activities, benchmarks, roles and timelines to achieve objectives.
- Evaluation design developed and documented to assess achievement of Plan goals and objectives, include method for CQI.
- Written summary of adoption process: procedures for and participants in public review, key issues raised, revisions included.

Using Evaluation of Data for Continuous Quality Improvement

Our approach to continuous quality improvement (CQI) will build on our Performance Indicator Project and draw upon the Institute of Health Improvement (IHI) Breakthrough Collaborative and IMPACT models and the Center for Health Care Strategies Best Clinical and Administrative Practices (BCAP) model, which are currently in use by the *Blueprint for Health,* and Vermont's RWJ-funded Community Depression Project. These strategies will create efficient feedback loops for ongoing assessment of the planning and implementation process. Combining key elements from each of these models will enable *Building Bridges* and the *Blueprint for Health* to collaboratively address improvements within systems, among practices

and across populations of children, youth, adults and elders. The CQI process will assess 1) how well the planning process is working, 2) implementation of the Mental Health Transformation Plan, and 3) whether the Plan continues to make sense over time, as it is implemented. As part of the CQI process, information about local challenges and innovations will be gathered and shared so that creative innovations can be promoted throughout the system.

Both overall project and specific Mental Health Transformation Plan objective process, performance, and outcome measures will be analyzed and shared with the TWG on a quarterly basis, and with the *Building Bridges* initiative as determined through the planning process. These meetings will use a learning session approach to assess the data, discuss barriers and challenges and suggest changes. Vermont has been successfully using this model with the Vermont Medical Home Project. It enables ongoing assessment of the process and rapid implementation of mid-cycle changes to better achieve project goals.

The CQI process will use various sources of data, outlined below, to monitor the project and make needed revisions in the process:

- Quarterly summary of data used in Process Evaluation highlighting areas of success and challenge.
- Qualitative data collection methods (e.g., interviews, open-ended survey questions) used to elicit information from stakeholders at local, regional and state levels as to strategies that are working well, not working well, and recommendations. Included in process and performance evaluation methods.
- Annual summary of Performance Evaluation to identify areas of success and areas needing additional attention.
- All project activities include evaluation component to elicit feedback from participants on what works, what needs improvement, and recommendations for action.

Evaluator Qualifications and Contracting

John Pandiani, Ph.D., Chief of Mental Health Research and Statistics Unit, will lead the evaluation team. Division staff on the evaluation team will include two full time data analysts and a full time data systems developer. Steven Banks, Ph.D., will provide ongoing statistical consultation to the team. These DMH team members will carry out quantitative data management and analysis. The qualitative evaluation consultant will take the lead on the process evaluation, qualitative elements of the performance evaluation, and the CQI process.

Vermont state contracting regulations require a competitive bid process for awarding contracts in excess of $10,000. Thus, we cannot identify an evaluation consultant at this time. We have, however, been extremely successful over the years in attracting skilled evaluators. We will post an RFP for the evaluation contract in Month One of the project. By the end of Month Two, proposals will be reviewed by the evaluation team in place at DMH with input from TWG Chair Charlie Biss. Criteria for selecting the winning proposal will include:

- Expertise and qualifications of evaluator(s), including systems evaluation, use of information for CQI processes, communicating evaluation results to a wide range of audiences, and knowledge of mental health systems
- Demonstrated skills with designing, collecting and analyzing qualitative data
- Realistic and achievable plan within the project time frame and budget

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Section H - Budget Justification, Existing Resources, Other Support.

Personnel

Job Title	Annual Salary	Level of Effort (FTE)	Salary Requested
Dynamic Leader	$ 81,575	1 FTE	$ 81,575
Administrator	49,412	1 FTE	49,575
Administrative Assistant B	37,274	1 FTE	37,274
Fiscal Design Specialist	55,203	1 FTE	55,203
Chief Research & Statistics (John Pandiani)	75,380	20% FTE	15,076
Research & Statistics Analyst	49,421	2 FTE	98,842
IT Data Base System Developer	55,203	1 FTE	55,203
Prevention Specialist	49,421	1 FTE	49,421
Public Education Coordinator	52,374	1 FTE	52,374
Communications Specialist	46,509	1 FTE	46,509
Field Specialist	49,421	5 FTE	247,105
Strategic Planner	46,509	1 FTE	46,509
Diversity Leader	46,510	20% FTE	9,302
			843,805

Fringe Benefits (30%) **253,142**

Overhead/Admin – Indirect Costs (20% of salaries) **168,761**

Travel **34,120**

Attendance of 5 team members to 2 joint Grantee meetings per year	Year One	Year Two	Year Three	Year Four	Year Five
Airfare ($800/person x 5 people x 2 trips/year)	8,000	8,000	8,000	8,000	8,000
Lodging ($170/person x 5 people x 3 nights x 2 trips/year)	5,100	5,100	5,100	5,100	5,100
Meals & Other ($132/person x 5 people x 3 days x 2 trips/year	3,960	3,960	3,960	3,960	3,960
Grantee attendance at cross-site evaluation meetings					
Airfare ($800/person x 2 people x 2 trips/year)	3,200	3,200	3,200	3,200	3,200
Lodging ($170/person x 2 people x 3 nights x 2 trips/year)	2,040	2,040	2,040	2,040	2,040
Meals & Other ($132/person x 2 people x 3 days x 2 trips/year	1,584	1,584	1,584	1,584	1,584
Grantee attendance at national conferences to present project findings					
Airfare ($800/person x 3 people x 2 trips/year)	4,800	4,800	4,800	4,800	4,800
Lodging ($170/person x 3 people x 3 nights x 2 trips/year)	3,060	3,060	3,060	3,060	3,060
Meals & Other ($132/person x 3 people x 3 days x 2 trips/year	2,376	2,376	2,376	2,376	2,376

In-State Meeting Expense/Other **35,500**

	Year One	Year Two	Year Three	Year Four	Year Five

State & Regional Stakeholder Meetings ($3,000/mtg x 4 mtgs)	12,000	12,000	12,000	12,000	12,000
Summit/Dialogue Meetings ($4,000/mtg x 4 mtgs)	16,000	16,000	16,000	16,000	16,000
Printing, materials, production and purchase	7,500	7,500	7,500	7,500	7,500

Information Technology

Analysis Data Systems Needs	200,000
Design, Purchasing and Licensing Costs	200,000
	400,000

Contractual Costs

Dr. Steven Banks (includes travel)	9,000
Dr. Daniel Fisher (includes travel)	9,000
Planning Grants to Local Districts (varying amounts to 12 districts)	500,000
Public Education Initiative	500,000
CQI/Process Evaluation	100,000
Training and Technical Assistance	100,000
(Will include consultation from SAMHSA Center on Women, Violence And Trauma	**1,218,000**

Total Year One: **$ 2,953,328**

JUSTIFICATION

PERSONNEL

Charlie Biss, Dynamic Leader will lead the Transformation Working Group and the project staff (described below). This is a full time commitment for the five years of the grant period. As a senior mental health policy manager and developer, Charlie will be responsible for setting overall policy direction, convening working groups, insuring that the evaluation meets major milestones, and supervising and providing direction to the project staff. Mr. Biss will interface directly with the Commissioner of Health, Paul Jarris, the Secretary of the Agency of Human Services, Mike Smith, and with the Honorable James Douglas, Governor. Finally, Charlie will represent Vermont at the three required project national meetings and in other related national forums. This salary is commensurate with significant policy and management leadership roles within Vermont State Government.

Project Administrator (Assistant) This yet-to-be-hired position will be responsible for working directly with TWG Chair Biss and providing overall project coordination. We will recruit for an administrator who has significant experience in the management and organization of large, multi-focus projects. The administrator will oversee the development of all written communications for the project, coordinate the overall staffing for the project, and provide staffing assistance to the Transformation Working Group. In addition, the project administrator will ensure that the local and regional level work is well coordinated with the state-level efforts.

Prevention Specialist This yet-to-be-hired position will be responsible for designing and overseeing the prevention and early intervention initiatives for Vermont's *Building Bridges* mental health transformation project. Specific roles will include the staffing and creation of the

6th *Building Bridges* work group on Prevention; designing prevention initiatives specific to children and families, adults, and elders; and working closely on the design and implementation of the social marketing campaign to broaden awareness of mental illness and promote access to early treatment.

VDH will provide in-kind support to the Prevention Specialist by convening a cross-cutting peer group that includes prevention specialists working in our Tobacco and smoking prevention initiatives, alcohol and substance abuse prevention specialists in Vermont schools, and key public health professionals working in VDH's District offices including from the WIC and immunization programs.

Public Education Coordinator This yet-to-be-hired position will be responsible for the *Building Bridges* project's social marketing campaign to end stigma, promote mental health as a health issue, and provide the public with information about how to access treatment. The individual hired for this position will draw on the fields of marketing, prevention, and health care. He/or she will oversee the contract to develop a sequential and broad approach to public information so that Vermonters recognize the early signs of mental disorders, know how to access early stage treatment and support, and so our communities support and welcome all citizens.

Communications Specialist This yet-to-be-hired staff will be responsible for ensuring regular communication between the state and local planning groups, the cross-cutting Blueprint framework groups (illness management, community activation, provider practices, and information technology) and the Transformation Working Group. This position will develop and staff a project Web page, weekly updates to the stakeholder community, press releases, and will cultivate a working relationship with the major media outlets in Vermont to place positive stories about resilience, recovery, and effective treatment. In addition, to help support the process of innovation, this position will regularly seek out new approaches that local communities are taking and broadly communicate these key learning to the entire stakeholder community.

Field Specialists Five, full time program specialists will be hired to staff and coordinate the cross-cutting Building Bridges work groups. These staff will also serve on the Blueprint Framework work groups to insure coordination between these two systems change initiatives. VDH will actively recruit among the mental health consumer and family communities for these positions. One staff each will be responsible for convening, organizing, reporting and generally supporting the following work groups: 1) Consumers and Families, 2) Providers, 3) Mental Health/Health Care Sector; 4) Communities, and 5) Information Systems. These field specialists will also work closely with the local partnerships at the community level to complete the needs assessment, to develop the strategic plan, and to carry out transformation activities identified in the plan.

Strategic Planner A full time position will be hired to establish and overall framework for the needs assessment and for the strategic plan development. This position will assist local groups and the Transformation Working Group to develop clear written plans based on their work. In addition, this position will coordinate the written products of the Blueprint work groups. This

position will be full time for the first three years of the project spanning the development and completion of the planning phase of the project.

Administrative Assistant A full time administrative assistant will be hired to provide secretarial support to the project team. The administrator will prepare mailings, maintain communications provide administrative support to project meetings, and help organize training and technical assistance events.

John Pandiani, PhD (Chief MH Research and Statistics) Twenty percent of Dr. Pandiani's time will be dedicated to the project. He will supervise the development and implementation of the outcome evaluation, assist in the design and oversight of the process evaluation (this component will be contracted for), supervise the Research and Statistics Analyst position and coordinate, with the IT section, the work of the Data Coordinator IT Specialist.

Research and Statistics Analyst Two, full time to-be-hired positions will be responsible for generating regular analytical reports on the required outcome measures and for the project evaluation. These reports will also create a feedback loop to improve the accuracy and comprehensiveness of data reported to our numerous systems. In addition, the analysts will assist in the production of reports that cross data bases (e.g. Hospital Discharge Data Set, criminal justice reporting, employment data, Medicaid claims processing data, MH service encounter data etc.) project reports, and for staffing the reporting on the required outcome measures.

Data Coordinator IT Specialist This full time position will be responsible for inventorying the contents and capabilities of the multiple data bases involved in the treatment, reporting, and oversight of mental health services. After completing the inventory, this position will work with the dynamic leader, transformation working group, and Dr. John Pandiani to identify the most critical information gaps in our information systems to sustaining the transformation project. In concert with policy leaders, the Data Coordinator will design plans to assure the efficient interface of existing systems to implement the transformation project plans including the necessary upgrades in IT systems and software acquisition.

Steve Banks, Evaluation Consultant This consulting role will assist the project evaluation team by providing mathematical and statistical consultation in support of the quantitative evaluation components of this project. These will include consultation regarding statistical case-mix adjustment to assure the regional comparisons present a fair assessment of relative performance, the appropriate use of the Probabilistic Population Estimation statistical procedure to measure the numbers of individuals from public mental health caseloads who are also represented on other caseloads and the value of services provided by those other private and public sector agencies, and quantitative measures of change in system performance over time. In addition, Dr. Banks will assist TWG Chair Biss and Dr. Pandiani in the design and development of new outcome measures and analytical procedures relevant to the evaluation of service system efficacy.

Fiscal Design Specialist This full time position will assist in developing the inventory of public and private funding streams that currently support the provision of mental health care in Vermont. The position will also assess the strengths and limitations of the various billing

systems in use and develop recommendations for the Transformation Working Group and Chair Biss about how these could more efficiently interface to streamline billing for practitioners and assure appropriate sub-recipient monitoring for payers. The Fiscal Design Specialist will help implement the transformation project plans including the design and upgrade of financial systems.

Diversity Leader The Vermont Building Bridges project will support 20% of the Department of Health's Office of Minority Health Coordinator. Working closely with project staff and the TWG, this position will assist in the development of culturally specific approaches and help insure that diversity and cultural competence are embedded in all project activities. This position will assist in bringing minority stakeholders to the project teams, work groups, and events to assist in the development of the strategic plan. In addition, it will interface closely with the communication specialist and social marketer to insure that critical perspectives of diversity and culture are well represented in our education approaches and communications plans.

FRINGE BENEFITS

The actual cost of fringe benefits (not a fringe benefit rate) will be reported as a direct cost of the program. The actual cost of fringe benefits varies from employee to employee based on salary, employee choice of health care plan, and employee election of certain other benefits. The usual, major components of this cost are FICA at 7.65% of salary, retirement at 9% of salary, and a portion – 80% for medical, 75% for life and 100% for dental - of the actual costs of the medical, dental and life insurance coverage selected by the employee. The cost of each employee's fringe benefits will be allocated to the program based on hours worked in the program relative to all hours worked by the employee. Based on the current cost of fringe benefits for employees in similar programs, we are estimating the cost of these fringe benefits at 30% of salary.

OVERHEAD /ADMINISTRATIVE COSTS

The Vermont Department of Health uses a Cost Allocation Plan, not an Indirect Rate. This Cost Allocation Plan was approved by the U.S. Department of Health and Human Services effective October 1, 1987. The Cost Allocation Plan summarizes and allocates actual, allowable costs incurred in the operation of the program. These costs include items often shown as direct costs, such as telephone and general office supply expenses, as well as items usually included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the salaries and wages paid in the program relative to the total salaries and wages paid in the department overall. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a percentage of program costs. Based on recent experience with similar programs, we would estimate these allocated costs at 20% of the direct salary ("Personnel") line item.

Information Technology (Analysis, Design and Purchasing) ($400,000 Vermont will use grant funds to analyze current information technology and systems across the public and private health care systems and determine methods for improving data sharing, monitoring, and reporting. Based on this analysis, Vermont will use funds for both the purchase of existing and the design of new data warehouse systems and data mining and data analysis and reporting tools (e.g.

Business Objects). Additional funds will be required for licensing of existing systems and maintenance of purchased and newly developed systems and tools.

Infrastructure Planning Grants ($500,000) Annual planning grants will be provided to the VDH District Offices to facilitate the development of local needs assessments in the project's first phase; strategic implementation plans in the second phase; and for Transformation pilot projects in the third and final phase. These grants will be used to defray the costs of meetings expenses and local travel, to provide planning participants with stipends to compensate them for time away from the provision of health and mental health services, to support meaningful consumer and family participation, and to defray the planning and coordination costs of the project at the local level.

Best Practices Training and Technical Assistance Fund The transformation project requires sustained training and technical assistance initiatives to help providers learn to be consumer and family centered, to assist in the implementation of evidence-based practices, and to provide health care communities with the technical assistance they will need in order to implement the transformation recommendations for the strategic plan. The resources in this fund will be used to purchase consultation and training expertise as requested by local communities and recommended by the Blueprint work groups and the State Transformation Working group. Dr. Daniel Fisher has agreed to kick-off the project in Vermont and to work closely with us in building bridges and developing common language and understanding between consumers and health and mental health care. providers. In addition, this fund will support "Summit Meetings" on each of the President's New Freedom Commission goals. ($100,000).

Contracted Services
Vermont State contracting procedures require an open and competitive bidding process for any contract over $10,000. Therefore, it is not possible for us to name specific contractors in this application.

Public Education Initiative In order for Vermonters to think of mental health as a critical component of overall health, citizens need general information about how to recognize the early signs of mental disorders and how to access treatment that works. In addition, positive messages about recovery and resiliency need to be developed to help counteract widely held beliefs reflecting stigma and prejudice about mental illness. While Vermont has designed and carried out successful social marketing campaigns to reduce teenage substance abuse, reduce drinking and driving, to promote HIV/Aids prevention, promote early detection and screening for a variety of illnesses, and to prevent youth from starting to use tobacco we have never undertaken a systematic approach to communicating health messages about mental disorders. We propose to issue a national Request for Proposals for experienced firms to design and carry out a social marketing campaign throughout Vermont about mental illness, treatment, resilience and recovery. ($500,000)

CQI/Process Evaluation Contract Conduct the process evaluation, collect the GPRA measures, convene focus groups and conduct key informant interviews, meet monthly with the Transformation Working Group and project staff to provide feedback on: 1) overall project implementation; 2) the degree to which stakeholders, especially consumer and family members

feel their participation is meaningful; 3) and to recommend corrective actions or changes to the project approach to better achieve transformation. ($100,000).

SECTION I. JOB DESCRIPTIONS

Dynamic Leader – Chair of Transformation Working Group

Responsibilities: Charlie Biss, Dynamic Leader, will lead the Transformation Working Group and the project staff. This is a full-time commitment for the five years of the grant period. Mr. Biss will convene and lead Transformation Working Group meetings, and will head the TWG Executive Committee that will make key policy and planning decisions. As a senior mental health policy manager and developer, Charlie will set overall policy direction, convene working groups, ensure that planning, implementation, and evaluation processes for Vermont's Mental Health Transformation Plan meet major milestones, and supervise and provide direction to the project staff. As TWG Chair, Charlie is ultimately responsible for carrying out the vision, goal, objectives and activities of Vermont's mental health transformation process.
Skills, Qualifications, Experience: The TWG Chair must be a recognized mental health leader with proven ability to lead significant change initiatives in challenging environments. He or she must be a visionary yet practical leader who has the respect of the governor and of the wide range of stakeholders involved in mental health system transformation. The Chair will have demonstrated success at leading complex organizations with significant budgets and collaborating across disciplines to achieve significant, sustainable results. The Chair will have demonstrated commitment to mental health system transformation, and to the concepts of recovery and resiliency, consumers as partners, and a prevention perspective.

Charlie Biss: Bio

Charles (Charlie) Biss has led the Child, Adolescent and Family Unit of Vermont's Division of Mental Health for the past 13 years. Mr. Biss is both the hands-on director of a large and complex state-funded system with multiple activities and providers serving 10,000 children a year, and a visionary leader, whose expertise in planning, implementing and sustaining far-reaching system reform in children's mental health is recognized far beyond Vermont. Mr. Biss has been a driving force in Vermont's renowned success with including families as partners in systems of care. His core values of inclusiveness, strengths-based, family-centered care are evident in every aspect of Vermont's system of care for children and adolescents with severe emotional disturbance and their families. Charlie was instrumental in helping Vermont's Agency of Human Services redesign its systems and policies to better reflect these values in its recent reorganization. Individualized service planning that responds to the diverse needs of children and their families is one of Charlie's mantras; we are confident that our transformed system of care under his guidance will include individualized and coordinated plans of care across systems and funders. As a national consultant with Georgetown University's National TA Center for Children's Mental Health and with the Federation of Families for Children's Mental Health, Mr. Biss guides other states through the difficult challenges of incorporating these values into practice through their SAMHSA/CMHS Comprehensive Community Mental Health Services for Children and their Families grants. Mr. Biss led this 5-year systems change grant in Vermont, as well as a more recent 5-year SAMHSA/CMHS grant that focused attention on the mental health needs of children from birth to age six and their parents, and increased understanding of prevention as a priority. A great tribute to Charlie's leadership is that he has crafted agreements with Vermont's legislature, governor, and other top leaders, including legislative changes and leveraged funding, that have ensured that the far-reaching impacts of these and other major grant-funded efforts, such as for respite care and transition services, are sustained long after the grants end.

CB Letter of Committment

Project Administrator (Assistant)

Responsibilities: The Project Administrator will work directly under the TWG Chair to provide overall project coordination. The Project Administrator will oversee project staffing and coordinate the work of the six TWG workgroups with the TWG Executive Committee, ensuring the TWG Chair is kept apprised of workgroup efforts, accomplishments and needs. He or she will provide staffing for the TWG and will play a major role in coordinating efforts integrating efforts of *Building Bridges* Workgroups with the *Blueprint for Health* workgroups. The Project Administrator will carry overall responsibility for written products and for communications and coordination concerning regional and local level work.

Skills, Qualifications, Experience: The Project Administrator will be someone with a successful history of project development, of managing large, multi-focus efforts and a strong supervisory background. He or she must be able to work independently, identify and resolve complex problems, and possess strong planning and organizational skills. The Project Administrator must have excellent communication skills and be a strong writer. Experience in public mental health is a plus but not required.

Prevention Specialist

Responsibilities: The Prevention Specialist will design and oversee *Building Bridges'* prevention and early intervention initiatives. He or she will staff the *Building Bridges* workgroup on Prevention/Public Health and will integrate Vermont Blueprint for Health prevention efforts and initiatives with Building Bridges. Key responsibilities will include designing prevention initiatives specific to children and families, adults, and elders, including specific groups with cross-cutting needs. The Prevention Specialist will also oversee efforts for those from diverse backgrounds and cultures, and work on the design and implementation of the project's social marketing campaign. Work of the Prevention Specialist will include program development, consultation, administrative and supervisory work for *Building Bridges* and coordinating efforts with various departments of the Agency of Human Services, prevention program providers, including consumers and families, and numerous other stakeholders involved in mental health transformation through *Building Bridges.*

Skills, Qualifications, Experience: The Prevention Specialist must have substantial professional background as a prevention leader, as well as advanced training and education, and/or clinical experience in the prevention field. He or she must be skilled at designing, leading, and assessing the impacts of prevention efforts from a public health perspective and be well-versed in the concepts of risk and protective factors. The Prevention Specialist must have demonstrated success in reaching a variety of groups through multiple prevention strategies.

Public Education Coordinator

Responsibilities: The Public Education Coordinator will lead the *Building Bridges* social marketing campaign to end stigma and discrimination, promote mental health as a health issue, promote access to early identification and treatment, as well as creating broad awareness and understanding of consumer-directed recovery and resiliency. This individual will draw on the fields of marketing, prevention, and health care. He or she will collaborate with the Transformation Working Group and the TWG workgroups to develop and implement a sequential and broad approach to public information so that Vermonters recognize the early signs of mental disorders, know how to access early stage treatment and support, and so our communities support and welcome all citizens.

Skills, Qualifications, Experience: The individual filling this position must have a history of designing and leading successful social marketing efforts for large and diverse target audiences. He or she must have excellent ability to work collaboratively to further the understanding of prevention and mental health promotion through a variety of strategies. Creativity, ability to take on significant multi-phase projects, public relations and promotional skills and excellent ability to communicate through a variety of mediums are required.

Communications Specialist

Responsibilities: The communications specialist will be responsible for ensuring regular communication between the Transformation Working Group and its workgroups, the cross-cutting Blueprint framework groups and the state-level and regional and local efforts related to *Building Bridges.* This position will develop and staff a project Web page, provide regular updates to the stakeholder community, press releases, and will collaborate with the Public Education Coordinator in cultivating a working relationship with the major media outlets in Vermont to place positive stories about resilience, recovery, and effective treatment. He or she will prepare *Building Bridges* brochures, fact sheets and other original materials. In addition, to help support the process of innovation, this position will regularly seek out new approaches that local regions and communities are taking and broadly communicate these key learnings to the entire stakeholder community.

Skills, Qualifications, Experience: The Communication Specialist will demonstrate excellent understanding of prevention and mental health promotion. He or she will be a skilled writer/journalist with substantial experience in writing, editing and coordinating release of news, articles and editorials, as well as appealing brochures and informational pieces for a broad public.

Field Specialists

Responsibilities: Five, full time program specialists will staff and coordinate five of the Building Bridges workgroups (in addition to the Prevention Specialist, who will staff the Prevention/Public Health workgroup). VDH will actively recruit among the mental health consumer and family communities for these positions. At minimum, the Consumers and Families Field Specialist will be a consumer or family member. One staff position each will be responsible for convening, organizing, reporting and generally supporting the following work groups: 1) Consumers and Families, 2) Providers, 3) Mental Health/Health Care Sector, 4) Communities, and 5) Information Systems. These field specialists will also work closely with the local partnerships at the community level and coordinate with the Strategic Planner to complete the needs assessment, develop action steps and tasks, and carry out transformation activities identified in the plan.

Skills, Qualifications, Experience: The Field Specialists will each be demonstrated content experts in the TWG workgroup to which they are attached. They will have an excellent understanding of the concepts of recovery and resiliency as they relate to mental health, and experience in prevention and health promotion from a public health perspective. The Field Specialists will be experienced at managing interagency/cross-discipline initiatives, and will have excellent communication and organizational skills. Priority will be given to candidates who are mental health consumers or family members.

Strategic Planner

Responsibilities: The Strategic Planner will work with the TWG Chair to establish the overall framework for the needs assessment and Vermont's Mental Health Transformation Plan development. He or she will coordinate planning efforts among TWG workgroup members and staff, as well as regional Department of Health/AHS involvement, and will be the primary writer for Vermont's Mental Health Transformation Plan. Following adoption of the plan, the Strategic Planner will provide expertise to ensure that Vermont's Mental Health Transformation Plan action steps and tasks translate into system transformation at the state, regional, and local levels. This position will assist the Transformation Working Group and the workgroups to develop clear written plans for their work, and coordinate them with the Blueprint for Health, other Department of Health initiatives, AHS state and regional planning, and federal and other grant resources. This position will be full time for three years, spanning the development and completion of the planning phase and first two years of implementation of Building Bridges.

Skills, Qualifications, Experience: The Strategic Planner will have an extensive background in leading planning efforts for complex and significant initiatives in mental health, health and/or human services. He or she must have excellent analytic skills and demonstrated expertise at assisting work teams to develop realistic, workable, and innovative plans for system change. The Strategic Planner will be a highly-skilled writer, able to create clear, coherent products to guide processes involving multiple partners and stages.

Fiscal Design Specialist

Responsibilities: The Fiscal Design Specialist will help design and implement financial system improvements that support mental health system transformation strategies.
The Fiscal Design Specialist will initially lead the effort to inventory the public and private funding streams that support provision of mental health care in Vermont. He or she will also assess the strengths and limitations of the various reimbursement systems in use and develop recommendations for the TWG and Chair about how these could more efficiently interface to streamline billing for practitioners and assure appropriate monitoring for payers. The Fiscal Design Specialist will provide guidance for new approaches to blending and leveraging funding streams that increase interagency collaboration and system efficiencies among *Building Bridges* partners.

Skills, Qualifications, Experience: The Fiscal Design Specialist will have extensive experience in managing publicly financed systems and a substantive academic background in public finance. He or she will have demonstrated ability to analyze, plan, and oversee implementation substantive and innovative improvements in fiscal systems. Substantial knowledge of public and private health care reimbursement systems and mechanisms is essential.

Research and Statistics Analysts

Responsibilities: Two Research and Statistics Analysts will be responsible for generating regular analytical reports on the required outcome measures and for the project evaluation. They will create reports that will also create a feedback loop to improve the accuracy and comprehensiveness of data reported to our numerous systems. In addition, the analysts will assist in the production of reports that cross databases (e.g. Hospital Discharge Data Set, criminal justice reporting, employment data, Medicaid claims processing data, MH service encounter data etc.) project reports, and for staffing the reporting on the required outcome measures. The Analysts will develop reports providing ongoing feedback to the full community of stakeholders, and report findings for inclusion in annual implementation progress reports.

Skills, Qualifications, Experience: The data analysts must be capable of identifying and analyzing program and operational needs for information and research, planning and conducting complex research and evaluation projects, and identifying database infrastructure requirements in order to answer stakeholder questions and respond to national reporting requirements, conducting analyses on project-specific monitoring tools collected by the evaluator, and developing research designs and data analysis methods for complex or difficult projects, or those that go beyond existing approaches. They must be able to work with existing behavioral administrative datasets, other human services administrative datasets and assisting in the development of *Building Bridges'* capacity to collect and report on key The data analysts will be able to conceptualize data needs and means of attainment for both existing and potential programs, working closely with Evaluation Team Leader John Pandiani and the database administrator in this task.

Data Coordinator/ IT Specialist

Responsibilities: The Data Coordinator/IT Specialist will be responsible for inventorying the contents and capabilities of the multiple data bases involved in the treatment, reporting, and oversight of mental health services. After completing the inventory, this position will work with TWG Chair Biss, the Strategic Planner, selected TWG members, and Evaluation Team Leader John Pandiani, Ph.D. to identify the most critical information gaps in our information systems to sustaining the transformation project. This position is responsible for evaluating state databases and creating shared databases between DMH and other related systems including the development of new database collection capacity. The database Coordinator will be responsible for administering and maintaining a Microsoft SQL Server database.

Skills, Qualifications, Experience: The Data Coordinator/IT Specialist will have extensive knowledge of Microsoft SQL (7 or 2000), experience with authoring stored procedures and triggers, and experience with business analysis, Web development and data warehousing. The Coordinator will be experienced at analyzing user needs and prioritizing requests for new or enhanced computer applications, design capacity plans based on DMH and other systems needs and current resources. He or she must be able to create proposals to provide step-by-step process for implementing a new or revised database service, research, evaluate, and recommend database management systems, software, compilers, and utilities, develop detailed specifications (functional, system, and program) using tested methods, conduct research to keep current on all technologies and methods useful to operations management and for system development.

Section J: SAMHSA Confidentiality and Participant Protection Requirements and Protection of Human Subjects Regulations

1. Protection from Potential Risks: There are no known risks from participating in or evaluating the activities of Building Bridges. Consumers or families will participate on a voluntary basis. They may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. In both cases, however, there is very little likelihood that critiques will be tied back to individual practitioners or agencies. Moreover, the purpose of stakeholder involvement, including professional staff, consumers and families is to honestly critique the current system as we transform it.

2. Fair Selection of Participants: Building Bridges is designed to include participation from a wide range of stakeholder groups, our efforts seek to include representatives across ages, genders, and racial/ethnic backgrounds. Participants will include consumer leaders, family members, advocates, and administrative and treatment professionals, as described in Section C. Individuals with mental disorders, and their family members, will be included in the stakeholder groups because of their ability to speak about the mental health system based on personal experience. No one will be excluded from participation in Building Bridges activities.

3. Absence of Coercion: Participation in Building Bridges activities will be entirely voluntary for members of each stakeholder group. In addition, participation in any surveys or interviews used to gather information for the project will be voluntary, without any direct or implied coercion.

4. Data Collection: Building Bridges evaluation and continuous quality improvement efforts will rely on data from existing sources as well as information gathered through stakeholder interviews, surveys, and documentation of activities, as described in Section F.

The DMH health information system includes provider specific unique person identifiers that allow for unduplicated counts but also protect confidentiality. Indeed, all data used by DMH is HIPPA compliant in terms of transaction and code sets and privacy and security. Data sets from other state agencies consist of HIPPA compliant limited data sets that do not allow the identity of individuals to be readily ascertainable. If new client-specific data is added to the evaluation design after completion of the Mental Health Plan, the same procedures will be used to protect confidentiality.

5. Privacy and Confidentiality: Building Bridges participant acknowledgement in any public or written documentation will be voluntary. Information gathered through surveys or interviews will not include any personally identifying data. The project will rely on data available through the DMH health information system which complies with HIPPA and 45 CFR 164.514(e) in protecting confidentiality. Data analyses and reports produced by Building Bridges will not include individually identifiable information. The project will not disclose any information in a manner that would violate the requirements of the HIPPA Privacy Rule.

6. Adequate Consent Procedures: Stakeholder participants will be free to participate in Building Bridges activities or not, as they desire. Requests to complete surveys will provide written explanations, including: (1) completing surveys is voluntary, (2) purpose of surveys, (3) benefits for completing surveys, (4) description of Building Bridges and role of the surveys, (4) no anticipated risks for completing surveys, (7) protections for confidentiality (surveys will be done anonymously), (8) whom to call with questions about the surveys and Building Bridges, and (9) costs for completing the survey and participants will not be paid.

7. Risk-Benefit Discussion: Participants in Building Bridges, including assessments through interviews and surveys, will be professional staff and stakeholders with a vested interest in the transformation of the mental health system. We do not anticipate risks any higher than those presented by everyday work activities. As mentioned earlier, some professional staff and/or consumers may be concerned that criticisms may jeopardize employment or services. Since the project seeks critiques to improve the system, and there is little likelihood that specific comments will be tied to individual practitioners or agencies, we anticipate this as a very low risk. The benefits of participation, on the other hand, provide a great deal of promise. We expect broad based stakeholder and professional staff participation to result in successful efforts to transform Vermont's mental health system, thus providing all of our citizens with a more effective system.

Protection of Human Subjects Regulations

We do not anticipate that any of our evaluation efforts will require compliance with the Protection of Human Subjects Regulations (45 CFR 46). However, if there are any questions about protection of human subjects, we will submit an application to the Agency of Human Services Institutional Review Board (IRB) to ensure that our activities comply with the requirements. The Agency's IRB has a well developed process, including the requirement that all applicants complete a web-based tutorial program reviewing the Protection of Human Subjects Regulations (www.ahs.state.vt.us/IRB).

Appendix 1: Letters of Commitment/Coordination/Support and/or Memoranda of Understanding

Appendix 2: Data Collection Instruments/Interview Protocols

Division of Mental Health Consumer Satisfaction Survey

Vermont Mental Health Consumer Satisfaction Survey

Please circle the number that best represents your response to each of the following statements about the mental health services you have received in the last year from Counseling Services of Addison County.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1.	I like the services that I receive……..	1	2	3	4	5
2.	If I had other choices, I would still get services from this agency…… ….	1	2	3	4	5
3.	I would recommend this agency to a friend or family member…… ……	1	2	3	4	5
4.	The location of the services is convenient (parking, public transportation, distance, etc.) …….	1	2	3	4	5
5.	Staff are willing to see me as often as I feel it is necessary.	1	2	3	4	5
6.	I am satisfied with my progress in terms of growth, change, and recovery…..……..	1	2	3	4	5
7	Staff return my calls within 24 hours……...	1	2	3	4	5
8.	Services are available at times that are good for me ……	1	2	3	4	5
9.	I am able to get the services I need……...	1	2	3	4	5
10.	I am able to see a psychiatrist when I want to……..	1	2	3	4	5
11.	Staff believe that I can grow, change, and recover……..	1	2	3	4	5
12.	My questions about treatment and/or medication are answered to my satisfaction……..	1	2	3	4	5
13.	I feel free to complain……...	1	2	3	4	5
14.	I have been given information about my rights……	1	2	3	4	5

15.	Staff respect my rights……..	1	2	3	4	5
16.	I am encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.)…..	1	2	3	4	5
17.	Staff encourage me to take responsibility for how I live my life……..	1	2	3	4	5
18.	Staff tell me what medication side effects to watch for…..	1	2	3	4	5
19.	Staff respect my wishes about who is, and is not, to be given information about my treatment…….	1	2	3	4	5
20.	I, not staff, decide my treatment goals…….	1	2	3	4	5
21.	Staff are sensitive to my cultural background (race, religion, language, etc.) ……...……	1	2	3	4	5
22.	Staff help me get the information I need so that I can take charge of managing my illness…….……	1	2	3	4	5
23.	Most of the services I get are helpful……...…	1	2	3	4	5
24.	Staff I work with are competent and knowledgeable……..	1	2	3	4	5
25.	Staff treat me with respect……	1	2	3	4	5
	As a direct result of services I received from Counseling Services of Addison County:					
26.	I deal more effectively with daily problems……	1	2	3	4	5
27.	I am better able to control my life……	1	2	3	4	5
28.	I am better able to deal with crisis……	1	2	3	4	5
29.	I am getting along better with my family…….	1	2	3	4	5

30.	I do better in social situations……...	1	2	3	4	5
31.	I do better at work and/or in school ……...…..	1	2	3	4	5
32.	My housing situation has improved…….	1	2	3	4	5
33.	My symptoms are not bothering me as much……...	1	2	3	4	5

During the last year: (please circle Yes **or** No as appropriate)

34.	Have you been employed? .....……..……	Yes	No
35.	Have you been hospitalized for medical treatment?	Yes	No
36.	Have you been hospitalized for mental health treatment?…	Yes	No
37.	Have you been arrested? …….	Yes	No

Is there anything else you would like to tell us?

1. What do you like most about the mental health services you get from Counseling Services of Addison County?

2. What do you dislike about the mental health services you have received from Counseling Services of Addison County?

3. Are there any other services you would like to get from Counseling Services of Addison County?

4. Other comments:

Please send me a summary of the findings of this survey. Yes ☐ No ☐

Survey completed with staff assistance. Yes ☐ No ☐

Thank you!

Appendix 3: Sample Consent Forms

Assurances – Non-Construction Programs. Use Standard Form 424B found in PHS 5161-1.

Certifications – Use the "Certifications" forms found in PHS 5161-1.

D**isclosure of Lobbying Activities** – N/A

Checklist